U.S. NAVY MEDICINE

June 1981

INSIDE:

SG Inspects C4

Graduate Medical Education

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COVER: Surgeon General of the Navy, VADM J. William Cox, observes the Combat Casualty Care Course in operation from an Army medical evacuation helicopter. Story on page 1. Photo by the Editor.

A Closer Look at C4

Earlier in the day I had seen them scurrying among the rocks and dust with their stinger-tipped tails poised for action. Now as I lay on my belly in the darkness, camera at the ready, the idea that a scorpion could be working its way down my collar made me wince. There was movement on the path in front of us. The Marine to my right cried "Fire!" and the stillness exploded with the staccato pop, pop, pop of small arms fire. Muzzle flashes from M-16 rifles illuminated the faces of several dozen screaming physicians getting their first taste of night combat.

The place was Camp Bullis in the rolling Texas hill country north of San Antonio. The cartridges were blanks and the combatants, participants in the tri-service Combat Casualty Care Course (C4).* This was the sixth day for them and the first and last for me. I had arrived in San Antonio the night before with VADM J. William Cox, Surgeon General of the Navy, to see what C4 was all about.

It had been a long day, up at 5, breakfast, and then after several briefings at the U.S. Army Health Services Command headquarters at Fort Sam Houston, it was off to Camp Bullis, a hilly, rocky, scrub-pined Army reservation of many dozen square miles. (Since its inception last year the Army has hosted the C4).

After jouncing along a rutted road in an Army van, we came upon some of the "troops"—Army, Air Force, and Navy physicians dressed not in the medical whites of their profession but in combat fatigues and camouflaged utilities. They were undergoing their sixth day of rigorous training and many looked tired and somewhat bewildered. For almost a week they had been putting in 18-hour days sharpening their skills in combat and disaster medicine, subjects unfamiliar to those who received their educations in civilian medical schools.

Photos by the Editor

VADM J. William Cox observes a C4 exercise in the field.

Military medicine in the field was a different story. The course participants had learned battlefield emergency procedures, skills like treating penetrating wounds of the chest and those caused by high velocity missiles. They had been taught to gain emergency access to the airway and splint and bandage using field medical kits. They practiced the transportation sequence, from recovering casualties under fire to the proper way to carry a litter. They loaded crackerbox ambulances and became acquainted with the military evacuation helicopter. Their realization that a "Huey" is not a flying emergency room came quickly. Few knew that litters are spaced 18 inches apart and that the noise and vibration make it virtually impossible to check a patient's vital signs. Nevertheless, their instructors had them attempt to take pulses and blood pressures and even insert IV needles in each other while zipping along at treetop altitude. They also became familiar with the configurations of the medically equipped C-141 and C-9 aircraft, for in a combat situation, these would be their flying ambulances.

Earlier in the week, at nearby Brooks Air Force Base, the physicians had learned to care for chemi-

*For more on the Combat Casualty Care Course, see *U.S. Navy Medicine*, July 1980 and November 1980.

A chopper has gone down in the area. Who will be medics and who will be litter bearers?

The patrol moves out . . .

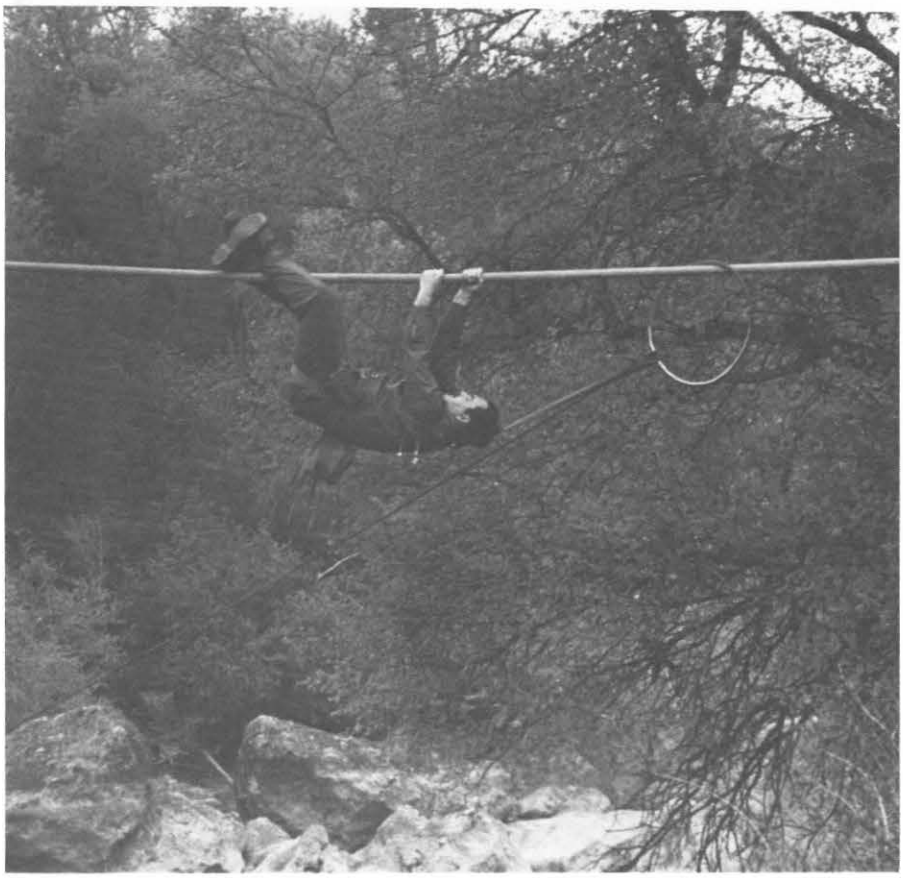
. . . and takes casualties.

cally contaminated casualties; donning protective garb and masks, they soon realized that difficult as it may be to treat patients through fogged goggles, it may someday become necessary.

Their final exercise before graduation would be a mass casualty drill in which they would triage and treat realistically moulaged patients. Said LTCOL Barry Wolcott, MC, USA, one of C4's founding fathers, "You'd think the physicians would be relatively blasé about this kind of exercise. After all, they know it's not for real. But the fact that their performance is being graded substitutes one kind of pressure for another. Although it isn't the pressure of combat, there's enough for them to get the feeling of what it's like to make decisions under trying circumstances."

This afternoon, the participants would go through various battlefield scenarios and be evaluated on each. We drove to one of several "lanes" where a search and rescue scenario was underway. The physicians had

A lane instructor briefs the troops. They have been cut off behind enemy lines . . . and must cross a deep gorge.



already chosen a leader who was being briefed by an instructor. A helicopter had gone down somewhere in the vicinity. They would have to locate survivors, treat them, and return with their patients. "You have four litters and two aid bags at your disposal. If you're not familiar with the equipment, I suggest you familiarize yourselves before you start out," advised the instructor. "You have a physician and a corpsman who will accompany your patrol. They will tell you what kind of injury the casualty has sustained," she went on, "and give you vital signs. None of you are physicians in this lane. You can have half medics and half litter bearers, or all medics, it's up to you."

The patrol quickly planned the mission. Five armed Marines would provide security. They moved out. Not 50 feet down the lane, a burst of automatic rifle fire rang out and the point man went down with a leg wound. Enemy snipers (Marines with blank-fed M-16s) were present. Everyone scattered. The elected leader quickly reached the groaning leatherneck and, as he began to drag him toward the tree line, there were more shots.

"You're hit. You're a casualty," shouted the instructor. Suddenly the pressure was on. Team members were turning into casualties with alarming suddenness.

"Down here," someone yelled. "Here it is. I've found the chopper."

With litters at the ready, they all ran toward the wreckage. Moulaged dummies representing crewmembers were scattered nearby. Someone tripped a concealed booby trap. More casualties. A chemical grenade exploded, unleashing a cloud of colored smoke.

"Gas attack! Get your masks on." The instructor slowly but loudly counted to 10 and then shouted "If you don't have your mask on, you're a casualty." Just then, a simulator exploded near the bunched up physicians.

In the medevac scenario, students stabilize dummies . . .

. . . and call for a "dustoff."

A smoke grenade marks the landing zone . . .

Photo by LT D.E. Garner, MSC

Photo by LT D.E. Garner, MSC

. . . and the "patients" are loaded aboard.

"You're a casualty," screamed the instructor.

"Who, me?"

"Yes, you. You all had better get out of there or you're all going to be casualties. The enemy has your range."

The uninjured loaded the stretchers and ran for cover. The participants had begun to feel the pressure and found it more and more difficult to concentrate on treating the injured. The instructor's cries of "faster, faster" kept the tension high. One litter bearer snared her boot on a vine and went down along with the patient. "Am I a casualty too?" the embarrassed doctor ruefully asked.

"No, pick up your patient and get moving," replied the instructor.

The winded and now decimated patrol finally returned to the starting point for a critique. According to the instructor, their performance was quite good. "Occasionally, entire patrols are wiped out near the crash site," she said.

We moved on to another lane. The scenario there involved stabilizing three critically wounded dummies. After that was accomplished, the radioman called for a "dust-off." One participant hurled a smoke grenade to indicate the landing zone (LZ), but as the chopper came in, it took enemy fire and suddenly veered off. Another landing zone several hundred feet away would have to be used. The docs grabbed the stretchers and ran toward the new LZ, all the while taking incoming fire. The Huey landed, they loaded their patients, and the operation was completed.

The last lane may have been the most demanding, especially for those who were not in the best physical shape. The lane instructor gave the scenario: They were part of a unit that had been cut off behind enemy lines. They had 45 minutes to move themselves and their casualties to a rendezvous or landing zone where they could be evacuated by helicopter. A Marine fire team would support them and provide security along the way. They had to organize and move out in five minutes.

It became a very interesting exercise. Who would be in charge? What route would they take? Who would carry the litters?

They found only one route available—a steep descent down a 40-foot cliff. For many, this was the first time they had to put their lives in someone else's hands—an ironic switch of roles for most physicians. After rappelling to the cliff base, they moved along a rocky creek bed with the Marines providing flank security. Suddenly they drew enemy fire and took casualties, thereby setting up a new situation. They would now have to treat the wounded, all the while coming under increasing sniper fire and a gas attack. There was much confusion and noise, surely the closest thing to a real combat situation they had yet faced.

As the patrol neared the rendezvous, they found a deep gorge separating them from the landing zone. They would have to crawl sloth-like, hand over hand beneath a rope. It didn't take anyone very long to see that in a real situation those who could not make it would be left behind. One by one, the physician-soldiers dropped from the rope, saved from a watery fate only by a safety harness. Those who made it across were given a hero's or heroine's welcome.

With the lanes completed, we joined the troops for evening chow at Blackjack Village, a M*A*S*H-like tent camp that had been home for the course participants. We ate our fried chicken dinner standing in a light drizzle that really couldn't begin to dampen the ardor of the war storytellers. Some I talked with admitted that a week before, they had been skeptics, doubtful that anything of value could be learned by playing soldier. One Navy internist said that C4 was one of the most valuable courses he had taken in or out of the service. Those who had never before slept under canvas, eaten C-rations, toted an M-16, or treated casualties with a field medical kit learned to respect those who had. For the guy who later that evening would find himself crawling through the brush with a camera, a tape recorder, and an imagined army of poisonous insects, C4 would be an experience not soon forgotten.

Since C4 was introduced in April 1980, approximately 700 physicians have been through it as students or faculty. The course, taught by instructors from all three services, is accredited through the Uniformed Services University of the Health Sciences for 52 hours of Catagory I of continuing education credit. Physicians completing the course will receive certification from the American Heart Association in advanced cardiac life support.

Ten iterations of C4 are planned for FY82. —JKH □

The SG joins the students for evening chow.

Tri-SARF

A Unique Facility Returns Patients to Duty

In May, U.S. Navy Medicine *ran part I of an article on the Tri-Service Alcoholism Rehabilitation Facility (Tri-SARF) at the National Naval Medical Center, Bethesda, MD. The six-week treatment program that was described is only the beginning for most patients. Recovery from alcoholism can be a long process, taking about two years; some would argue that recovery can take a lifetime. How Tri-SARF prepares the patient for the day he or she "graduates" from the program and returns to his ship, platoon, office, or family is the subject of this month's conclusion.*

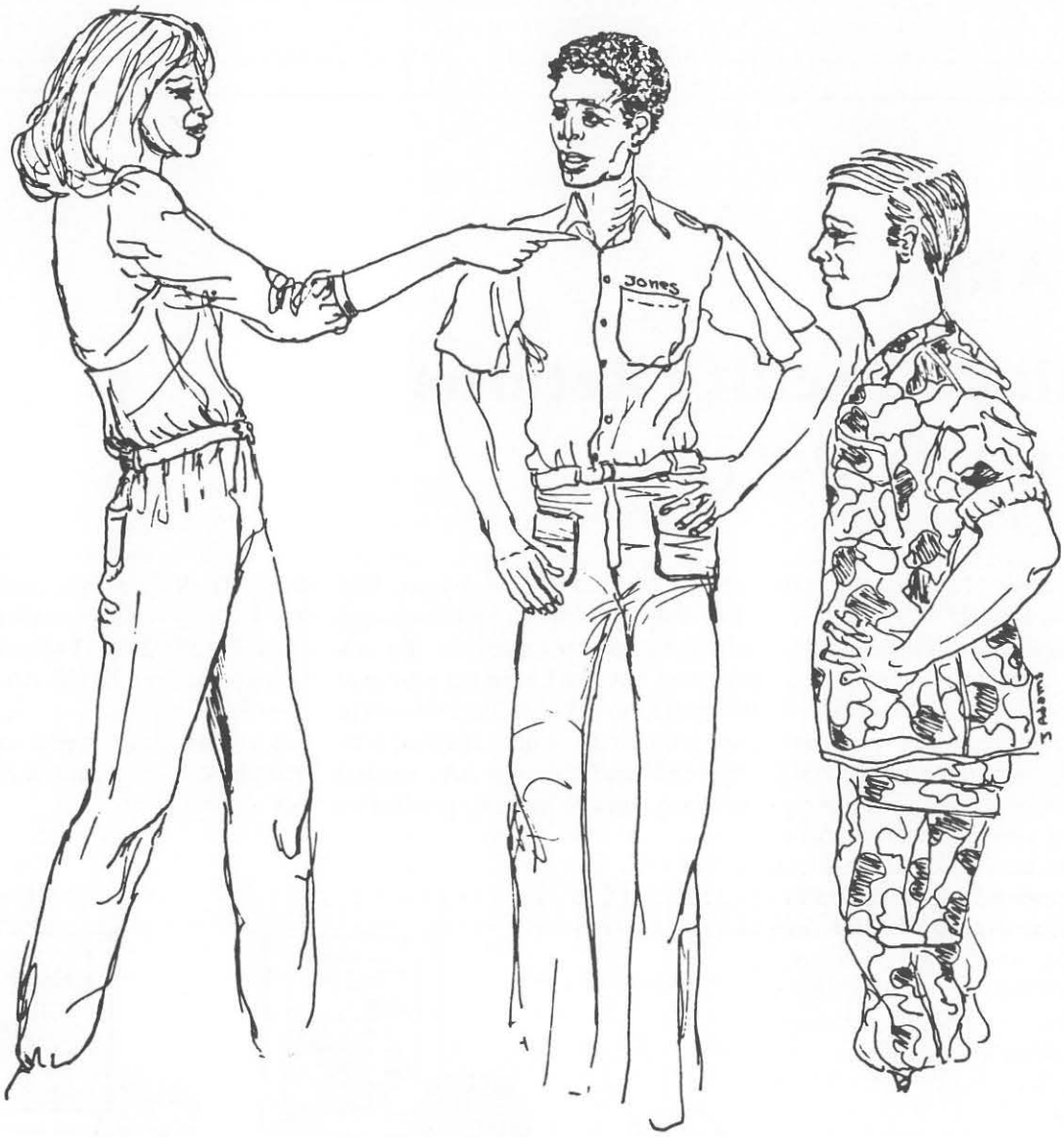
Alcoholics Anonymous

AA is perhaps the most essential ingredient in the Tri-SARF program. Without it, long-term recovery from alcoholism is impossible. What is this fellowship known as Alcoholics Anonymous and how did it originate? AA traces its beginnings to a conversation between a New York stockbroker and an Akron, OH, physician some 46 years ago. Both men, with each other's help and the aid of a physician, Dr. William D. Silkworth, were able to recover from their alcoholism and help others to do the same. By 1939, there were several self-help groups operating on the model they created and the fellowship that evolved published a book entitled *Alcoholics Anonymous.* The "Big Book," as the members began calling it, not only outlined the AA program, but also became a source of inspiration to AA members who read how other alcoholics reached the "bottom" and through AA, worked their way back to normal, productive lives. By 1976, it was estimated that AA's worldwide membership exceeded 1,000,000. Two years later, there were over 30,000 AA groups in over 90 countries.

The Big Book itself, now many printings later, concisely outlines AA's principles:

Art by Juanita Adams

Tri-SARF graduates are encouraged to participate in home AA groups.



Psychodrama or role-playing often helps the alcoholic put his or her life in perspective.

It was thought that no alcoholic man or woman could be excluded from our Society; that our leaders might serve but never govern; that each group was to be autonomous and there were to be no fees or dues; our expenses were to be met by our own voluntary contributions. There was to be the least possible organization, even in our service centers. Our public relations were to be based on attraction rather than promotion. It was decided that all members ought to be anonymous at the level of press, radio, TV and films. And in no circumstances should we give endorsements, make alliances, or enter public controversies.

Although the 12 basic principles of AA then go on to trace the pathway to sobriety, the essence of the therapy is the simple one-on-one relationship between the recovering alcoholic and the alcoholic who desires to free himself from the bondage of alcoholism.

The Tri-SARF introduces patients to AA their first day, and every day for the six weeks they are in treatment, they attend a meeting in the surrounding community. Once a week, the unit holds its own meeting on the premises. The patients organnize, contact and invite speakers for

the meeting, and learn to become part of their unique fellowship most of them will depend on for the rest of their lives.

The Tri-SARF's treatment program is very compatible with AA. In combination, the two work far better than either would by itself. "When you get a combination of a substantial treatment program such as this with a good, strong AA program, people make very quick and dramatic improvement," says Roger Roark, Tri-SARF's Clinical Coordinator.

Not surprisingly, AA offers the best followup support system available. The six-week Tri-SARF program is but a beginning in the recovery process. Without adequate followup, many patients would suffer relapse. In fact, many recovering alcoholics find the toughest time of all occurs when they leave treatment and try to readjust to the environment they once were part of. The "friends" they knew were drinking friends. Once the alcohol is removed from the relationship, there often is little remaining. One of the best places to find new friends is in AA. The fellowship not only offers continuing help with their illness but when a recovering alcoholic must change his or her lifestyle and circle of acquaintances, AA is one of the best places to do it.

Aftercare

As the Tri-SARF patients reach the fifth week of treatment, they are asked to submit their aftercare plans. Have they contacted an AA sponsor and an AA chapter on or near their home or military post? How often will they attend meetings? Will they join a home group? If medically prescribed, will they continue on Antabuse?

The Tri-SARF graduates are encouraged to attend a minimum of four AA meetings a week and participate in a home AA group—a group in which the patient feels comfortable and can develop close relationships. This participation may substitute for one of the four regular AA meetings.

The Tri-SARF holds periodic alumni and aftercare meetings of its own. Former patients, particularly those who live in the Washington metropolitan area, are encouraged to attend.

Maintaining contact with former patients for at least a year after discharge is another important Tri-SARF aftercare consideration, one which helps determine whether the graduates have assumed responsibility for their own recovery.

Education

Besides treating patients, the Tri-SARF conducts several educational programs for health care professionals. All psychiatry residents and psychology interns assigned to the National Naval Medical Center rotate through a six-week program. A two-day health care professional course on alcoholism is offered monthly. Once a month for two weeks, visiting professionals—physicians,* nurses, counselors, commanding officers, recruiters, and health care administrators—get an intimate glimpse of how the Tri-SARF alcohol rehabilitation program operates. The course, complete with clinical lectures and staff-led seminars, teaches them to recognize the symptoms of alcoholism and offers guidance in how to confront and refer the alcoholic patient. The visiting professionals go through many of the same program experiences as the patients.

Experiencing alcoholism and its treatment firsthand is an eye opener for the participants. Those who once thought of alcoholics as weak-willed derelicts suddenly find themselves becoming more tolerant. One nurse who worked with end-stage alcoholics came because she found it had become increasingly more difficult for her to empathize with patients that

*Physicians attending the course receive 80 continuing medical education credits.

AA means fellowship, mutual support, and shared experiences.

had drunk themselves to death. The course profoundly moved her and she returned to duty with a renewed commitment.

The Meaning of the Tri-SARF

What is the significance of alcohol treatment programs like the Tri-SARF? Do they fulfill their mission of rehabilitating the alcoholic and making that individual a productive administrative officer, infantryman, line commander, physician, aviator, seaman, air traffic controller, or counselor? In times of belt-tightening and austerity, another question must be asked, especially by those who plan military budgets. Are such programs cost-effective?

The answer to all these questions is an unqualified yes. Overall, the success rate for Navy alcohol treatment centers similar to the Tri-SARF is between 70 and 80 percent. These figures are based on the premise that two years after discharge from a rehabilitation unit, the person is at work, doing a good job, and has not been in any trouble as a result of alcohol. And if that individual has left the service, it has been under honorable conditions.

What about cost? Consider that the Navy spends almost $5,000 to recruit a sailor, send him to boot camp, and graduate him from a class "A" technical school. Presuming that the individual acquires an alcohol habit and must be discharged, another sailor must be recruited and trained. To discharge a senior enlisted member or a highly trained officer-professional raises the cost significantly, not to mention the immeasurable loss of that individual's experience. For about $37 per day or $1,600 for the six-week program, the Tri-SARF can return a recovering individual to full duty.

But cost savings notwithstanding, rehabilitation is a sound investment for another reason. Can one truly put a price on salvaging a human being? What, then, is the so-called "bottom line?"

Not infrequently, the Tri-SARF alumni come back to speak at patient community meetings about how they have fared since they left. They talk of sobriety, of newfound and productive relationships, of their participation in AA, and of a revitalized family life. Some have become counselors themselves in treatment programs of their own branches of service.

Almost everyday, the Tri-SARF counselors receive calls or visits from former patients reporting on their progress. Recently, a Tri-SARF graduate told her former counselor about her new life—how she tumbled from the euphoria following her treatment to the harsh reality of a tough everyday existence, and how she adjusted. She talked about her AA meetings and how there were new goals to set and work toward.

Every so often, a former patient will drop by simply to say "Thank you for my life." That's the bottom line.

Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him,* praying only for knowledge of his will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

U.S. Navy Medicine *would like to acknowledge the gracious assistance of the staff and patients of the Tri-SARF: CAPT George Negron, MC, USN, Commanding Officer and Chief of Service; Nonie Burnett, Director of Inpatient Services; Roger Roark, Clinical Coordinator; MAJ Phil Moser, USAF, Assistant Inpatient Director; LTCOL Art Harris, USA, Aftercare Director and Military Liaison; MAJ David Anna, NC, USA, Educational Director; SSGT Bob Yarbrough, USMC, counselor; SP5 Jerry Rogers, USA, counselor; LT Cindy Sennett, NC, USN, nurse and counselor; Bill Fatheringham, counselor; MAJ Frances Olson, NC, USAF, Outpatient Director and counselor; CAPT Bill Handorf, USA, Family Director; Lynn Davis, and Karla Boluda. —JKH* □

Alcohol Glossary

AA (Alcoholics Anonymous)
A worldwide self-help organization in which members help each other recover from alcoholism in a type of group therapy setting that utilizes common experience for mutual support.

Al-Anon
An organization patterned after Alcoholics Anonymous in which *adult* persons who have a significant relationship with an alcoholic help each other.

Al-Ateen
An organization patterned after Alcoholics Anonymous in which *adolescent* persons who have a significant relationship with an alcoholic help each other.

Alcoholism
A disease characterized by the dependence on alcohol and loss of control over one's drinking. It is this nation's number one drug of abuse. Recent estimates indicate that between 12 and 15 million Americans suffer from alcoholism.

Alcohol Rehabilitation Center (ARC)
A separate command of the line of the Navy that provides residential rehabilitation within a structured military environment.

Alcohol Rehabilitation Service (ARS)
A clinical service organized within a Naval Regional Medical Center or Naval Hospital that provides residential rehabilitation in a medical environment.

Antabuse
A drug (disulfiram) used as part of an alcohol treatment regimen. It will cause an unpleasant reaction in the presence of alcohol, thereby aiding the recovering alcoholic to resist temptation.

Ascites
A by-product of chronic alcoholism characterized by the accumulation of serous fluid in the abdominal cavity.

Blackouts
A condition characterized by failure of vision, momentary unconsciousness, and loss of memory. A common by-product of chronic alcoholism.

Cirrhosis
The most serious or final stage of liver injury and degeneration. Chronic alcoholism is the most common cause.

Co-Alcoholic
A family member of an alcoholic. Co-alcoholics are both victims of and contributors to the disease.

Counseling and Assistance Center (CAAC)
Navy outpatient units that provide assistance to individuals and their commands in the processing and disposition of personnel with alcohol and drug related problems.

Denial
The attempt by the alcoholic to convince himself and others that he is not a victim of alcoholism. Overcoming denial and admitting that one has lost control of his habit is the first step on the road to recovery.

Drunkenness
A temporary loss of control over one's physical and mental powers caused by excessive alcohol intake.

DWI (Driving while intoxicated)
A frequent legal problem faced by alcoholics.

Enabler
A compulsive friend or family member who aids and abets the alcoholic's addiction by coming to his or her rescue. The enabler denies the alcoholic the opportunity to suffer the consequences of his actions and seek help for the illness.

Ethyl Alcohol (C_2H_5OH)
The common ingredient in alcoholic beverages. It acts as a depressant drug that slows the activity of the brain and spinal cord.

Hangover
The body's reaction to excessive drinking. It may be characterized by gastritis, anxiety, fatigue, and headache.

Intoxication
The state of being poisoned, a condition produced by excessive use of alcohol.

NASAP (Navy Alcohol Safety Action Program)
A Navy educational and awareness program administered under a university contract designed to educate naval personnel to the dangers of alcohol.

Pancreatitis
Acute or chronic inflammation of the pancreas often caused by alcoholism.

Rehabilitation
A structured process whereby a person suffering from alcoholism is restored to effective service.

Teaching a New Lifestyle

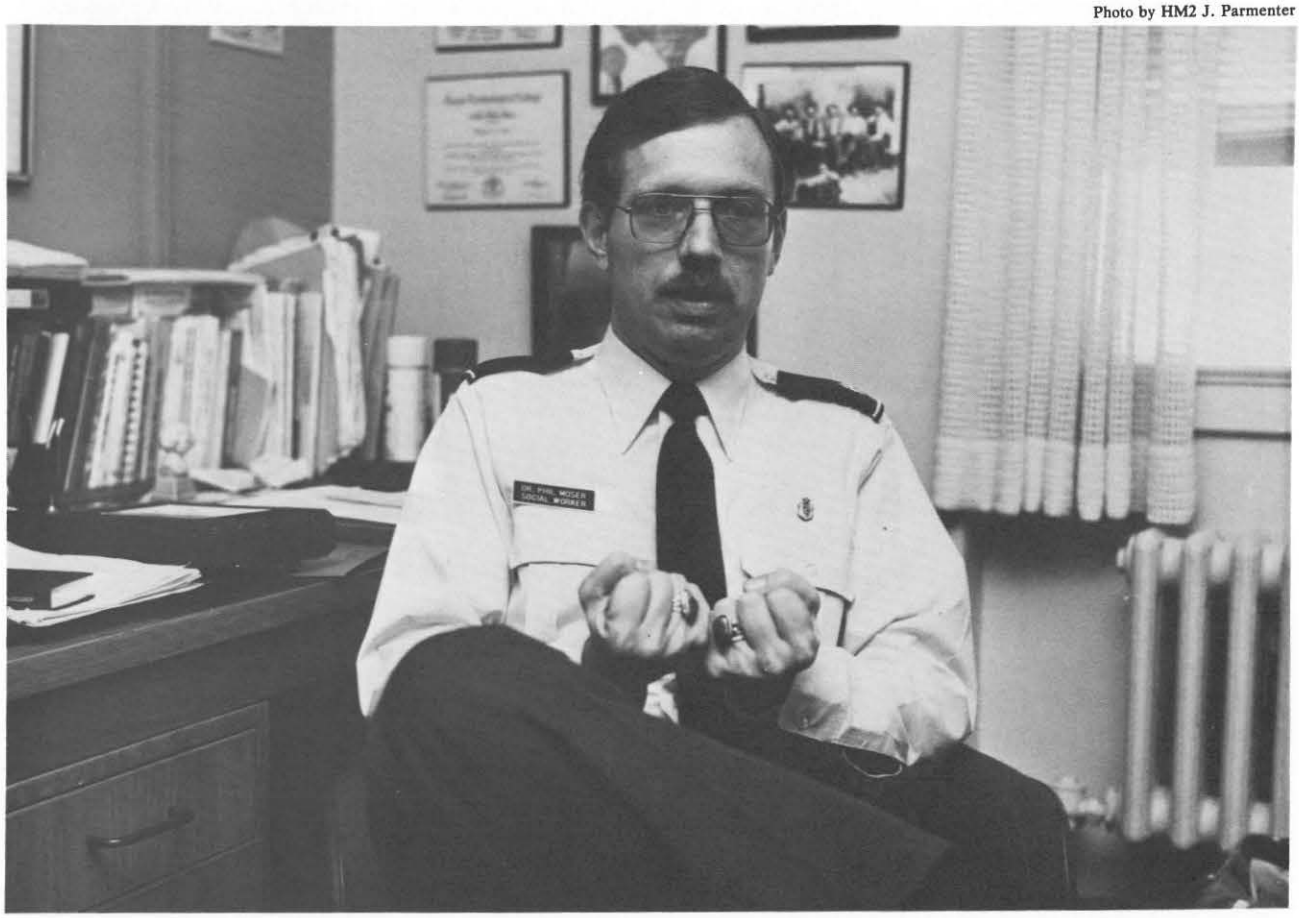
Simply taking alcohol away from the alcoholic is no longer considered an effective treatment for alcoholism. Attitudes, life patterns, and, in some cases, one's friends and acquaintances must change. Many recovering alcoholics discover that without alcohol, they have time on their hands—time to repair old relationships and develop new ones, time to explore new places and participate in varied activities. In short, the recovering alcoholic now has a reborn opportunity to develop a constructive lifestyle, one that is essential for long-term recovery.

Teaching Tri-SARF patients about lifestyle and leisure is one of the jobs of Air Force social worker MAJ Phil Moser. The friendly and easygoing Texan bases his lectures on personal experience and speaks with the understanding and authority of a man whose own life has been touched by the tragedy of alcoholism. U.S. Navy Medicine *spoke with him after one of his lectures on leisure time.*

USNM: How were you assigned to Tri-SARF?

Dr. Moser: It's an interesting story. Several years ago, the Air Force asked me to be the director of an alcohol treatment center in Weisbaden, West Germany. I told them I wasn't interested. In fact, I had been trying to get away from drunks all my life. My natural mother and my adoptive father were alcoholics; my mother even-

Photo by HM2 J. Parmenter



MAJ Moser

tually committed suicide as a direct result of alcoholism. My superiors weren't interested in excuses. "You're on the mental health staff," they told me, "and we need someone to work with the alcoholics." I reluctantly agreed but with reservations. I remembered what it was like growing up in an alcoholic home and how terrified, angry, and insecure I felt. But I found a very interesting thing about recovering alcoholics. They are recovering alcoholics and not drunks. And as sober people, they're sane, eager to learn, motivated, and they're fun and easy to work with. Once the alcoholic knows you really care, he's grateful.

Once I became part of that environment and found that alcoholics not only responded but responded to me as a person, I became very excited. When I again got the chance to become an alcohol director, I said yes.

But first I had to go to the Navy treatment center at Long Beach, CA, and learn from the inside out what it meant to work in this field.

What did the program include?

I thought it meant taking a few courses. I figured I knew all I needed to know about the etiology of alcoholism. I had a lot of schooling, a masters degree, and even a Ph.D. What else, I thought, was required?

I got to Long Beach and was placed in a small group therapy session, much like what we have here. They asked me:

"Who are you?"

"I'm the director of an alcohol treatment center."

They said "No, who are you?" All of a sudden I began to get that anxious feeling. "What do you mean?" I asked.

"Who are you in terms of drinking?" Suddenly, I realized they were beginning to get down to where I lived. I said I had alcoholics in my family but they didn't touch me. I had been out of that environment for a long time. They all nudged each other and chuckled.

"Oh, you're a co-alcoholic!" It was like a slap in the face.

"I'm not a co-alcoholic. I don't have a drinking problem. I don't even drink." They said "You're still a co-alcoholic."

They took me apart for two days and then put me together again. By the end of those first two days, I learned what it meant to be a co-alcoholic. And when I understood what it meant to be one, I felt a great sense of relief. It's almost like a spiritual awakening, as if someone touched me on the head and said, "You're healed!" No longer would I have to cover up my family background or worry about becoming a drunk myself.

I went back to my unit feeling a lot of enthusiasm and I still have it. When I came here, it was even more exciting. There are more people here to treat, more things going on, and more opportunities to try out new things. This is still an imprecise science. We're still learning. Maybe I can be part of finding the answers so more people won't have to have parents die or have the experience I had as a kid.

I noted from your lecture on leisure that you not only teach people how to enjoy themselves without alcohol but also ways to change their entire perception of themselves.

Yes. It's an attitudinal, spiritual sort of thing. For years, through the use of AA, which was the only thing we had for years to get alcoholics to stop drinking, we had a lot of sober alcoholics that were tense, unhappy, irritable, and went to AA meetings seven nights a week. It still wasn't enough. What was missing was a lifestyle change. They knew what they couldn't do anymore but didn't know what to do in place of it. Many alcoholics think people who aren't alcoholics lead very boring lives. Part of our job is to show them that there are some very exciting things they can do now that they have the time and the money. We emphasize how they can spend this leisure time with people or by themselves.

I understand everyone is going to the zoo tomorrow. Did you pick the location?

They picked the zoo. They voted on it. Once a month we go on a community field trip. We go to the Smithsonian. When the weather is nice we'll go to a park, play volleyball, softball, have a picnic. A few of us went to the National Cathedral a few weeks ago and everyone had a wonderful time. Some got involved doing brass rubbings; others got a real appreciation for stained glass. A few just wandered the grounds. When they got back, they couldn't wait to tell the rest of the patients what they had seen. It's finding out by exploring what's out there and learning that one can have fun and be excited about life without alcohol. —JKH

Alcoholism the Disease—A Nurse's Viewpoint

LT Cindy Sennett, NC, USN, is a clinical nurse assigned full-time to the Tri-SARF. She has been there 17 months, having worked previously as a surgical nurse at NRMC Portsmouth, VA, and a psychiatric nurse at NRMC Okinawa.

U.S. Navy Medicine *talked with her about alcoholism as a disease and what unique role the clinical nurse plays in an alcohol rehabilitation facility.*

USNM: Did any of your previous assignments prepare you for working in an alcoholism rehab unit like this?

LT Sennett: When I was stationed in Okinawa, I worked in the psychiatry service. It was very helpful to have that experience. There's a lot of similarity between alcoholic behavior and abnormal behavior. But alcoholic behavior is a result of the drug—alcohol. I can look at a patient now and determine that something is not right, that something is amiss.

Are there other similarities between alcoholism and mental illness?

Often, people who have coping problems handle them with alcohol. They sedate themselves. Psychosis is handled much the same way—with tranquilizers. It's not uncommon to find someone here with a psychosis who is self-medicating with alcohol. When you remove the alcohol, the psychosis rises to the surface.

Is it more difficult to handle alcoholic patients than psychiatric patients? Do alcoholics try to manipulate you?

Alcoholics have been manipulating themselves and distorting reality. The disease has distorted what really exists.

What kinds of things do the patients try to get away with?

They try to bend lines of authority and the rules. Some decide that a certain rule doesn't apply to them. It's really a control issue. The first step in AA, for example, is to admit to yourself that you are powerless over alcohol and that your life is out of control. We come in and say "For six weeks, it's our way. Your way hasn't worked. Here are the rules, these are the things you will be doing, and these are our expectations."

In other words, you are applying discipline where very little exists.

Yes. We are trying to put some structure into the alcoholic's life.

What is a typical day here for you?

I'm usually here about 7. By 0730 I get the report from the previous shift, review patients, and determine who is going to be admitted. What does the sick call roster look like? How many will have to see the doctor? After report, we have a staff meeting from 8 until 0830, in which we coordinate activities. From there, anything can happen.

We usually have people admitted in the morning. With sick call, I followup on the patient—what the problem was and what's being done about it. I also coordinate all the consults that come to the unit. In any one day, it's possible to have three or four consults that have to be divided among the counselors.

What types of consults are they?

The formal consults are usually from the hospital [NNMC]. There are patients who, in the physician's eyes, have a problem with alcohol. We often see people with recurrent chronic gastrointestinal problems. It's wise to check into these cases. Alcohol is an irritant and it causes serious problems.

Are they all legitimate referrals?

Oh, yes. We have very few inappropriate referrals. Those we do get are usually people with drug addictions.

Who detoxifies those patients who require it?

The hospital does that. Although withdrawal can be life-threatening, most people here do not have significant problems. They may have the shakes or their stomach may be a little upset and that's all there is to it. However, anyone who develops the shakes or severe abdominal cramping could just as easily develop DTs (delirium tremens).

Has that ever happened here?

We've had one case that I'm aware of.

How many patients does the hospital send over a week?

Last week we had seven referrals. This week we have had four.

This is only Wednesday.

It's very hairy when we get three in one day. Sometimes the patients are self-referred.

You mean you not only get referrals from the hospital but someone who feels they have a problem can walk in the door and say "I've

LT Sennett Photo by the Editor

got an alcohol problem, help me."

Oh, yes. We have no idea on any given day how many may come in.

You have a patient who is either a referral or a walk-in. He checks in here and says "I have a drinking problem." What do you do?

We go ahead and interview him and find out what the problem is. Why do they think they have a drinking problem? I often start off by saying: "Tell me about your drinking." He may respond "I don't drink too much."

"Well, how much is too much?" And then I try to go after the specifics, trying to develop an atmosphere of trust. You have to be nonjudgmental, conveying the idea that you are interested in the fact that they are concerned about drinking. I want to help them evaluate what they're seeing as a difficulty using my own experience. A lot of this is just experience. You get a feel for what the patient is saying and decide what to do.

Many alcoholics have a deep sense of personal failure and defeat. I try from the very beginning to let them know that they are ill. No one expects an individual to be able to control their bronchitis or their leukemia just by will. You can't control diabetes by wishing. Part of the disease called alcoholism is that you have no control.

What do you do about the patient whose drinking may already have affected marriage, job, relationship with children, the guy whose world is literally falling down around his ears?

I ask them to start sorting out problems. "Right now, let's not worry about the children. Your marriage is the main concern. Do you think your drinking is the main cause of the fights with your wife? Does she complain about your drinking? Do you think you'd have these problems if you didn't drink? Have you ever had a period when you didn't remember what went on and someone has had to fill you in as to what you were doing? How do you feel when you don't drink? How do you feel the morning following your drinking?"

I then look through the health records, keeping an eye out for gastrointestinal disturbances, hepatitis, pancreatitis—any history of gastric bleeding. "What was your drinking like when you went to the doctor after you vomited up blood?"

"Oh, gee, I was really drinking heavily then," he might reply.

"Did your doctor say anything to you about not drinking?"

"Yes. And I stopped for awhile but I seemed to have gone back to it worse than before."

What I'm doing is going through the symptoms of alcoholism and asking if these things have happened. People respond a lot more openly when you don't ask them pointblank questions like "Have you ever had a blackout? Have you ever experienced tremors?" You are communicating to them the idea that you know what their life has been like. And they usually respond with "Wow, I didn't think I could be an alcoholic!"

"Well, what's an alcoholic to you?"

"Oh, that's that bum who vomits in the gutter."

Pretty soon, they may see the connection between their symptoms and those of the stereotyped derelict. Sometimes, they already know they're alcoholic. More often, it never occurred to them because their picture of an alcoholic is so limited. You widen their view and let them know it's a disease that can be treated. Their life can change. You let them know that there are many people who have changed and have changed into happier individuals. —JKH

MSC Survey Results

Organizational Commitment

LCDR Mark C. Butler, MSC, USN CDR Paul T. Bruder, MSC, USN Allan P. Jones, Ph.D.

This is the fifth article in a series resulting from the Medical Service Corps survey conducted in April-May 1980.

As noted in several recent articles, social scientists and practicing managers alike have become increasingly interested in issues related to organizational commitment. In a broad sense, such interest is motivated by the belief that a high level of commitment leads to a more effective work force, especially when effectiveness is seen in terms of high levels of job satisfaction, lowered incidence of absenteeism, and reduced turnover. Both empirical and theoretical studies of this concept have largely concentrated on identifying antecedents and outcomes of commitment and have consistently found that organizational commitment is an important variable in increasing understanding of the work behavior of individuals within the larger organizational context.

Although many definitions of the organizational commitment concept have been offered, that cited by Hom and Hulin is most widely accepted, namely: "employee identification with and involvement in a particular organization." Characteristically, the more committed an employee is, the more likely that employee will be to accept organizational goals and values, to exert effort for the organization, and correspondingly to report higher levels of job satisfaction. In turn, such employees are more likely to remain with an organization longer.

As increasing numbers and types of professional people are employed by organizations, the question arises as to how role differences might influence one's level of commitment. Since professionals more often than not receive their training outside the job, it is possible that their value orientations and professional reference group affiliations exert influence or compel them in directions or toward commitments which differ from those required or expected of the employee in his or her workplace.

Following earlier work by Gouldner and others, an emphasis in recent research on organizational commitment among professional personnel has focused on two major role orientations which may be assumed by individuals. One is referred to as a bureaucratic (general administrative) role orientation and the other as a professional (occupational specialty) role orientation. The first is seemingly chracterized by an interest in or orientation to the functioning of organizations per se. The second is more of an orientation to the technical, substantive, or normative issues of one's professional specialty. Professionally role-oriented individuals who would be attuned to reference groups outside their work organization as vehicles to professional advancement and growth, might be less likely to report high levels of commitment to their organizations of employment unless such are perceived as being instrumental to meeting professional as well as personal needs. Alternatively, acquiring a bureaucratic role involves learning skills appropriate to organizational environments. Some of these are administrative. However, it also includes the acquisition of and identification with organizational values and goals and a concomitant increase in organizational commitment. Individuals who incorporate a combination of professional and bureaucratic characteristics into their roles could be expected to experience somewhat greater likelihood of role conflict. This would be especially true as the values and demands of one's profession and its reference organizations are at odds with those of one's organization of employment.

With that as background, the present study examines organizational commitment in relation to role orientations and other job attitudes among MSC officers. Derived from the MSC survey conducted last year, the construct of organizational commitment is defined in this study by a summary scale of seven items, examples of which are: "I am proud to tell others I am part of the Navy;" "I talk up the Navy to my friends as a great organization to work for;" "I am glad I chose the Navy over other organizations I was considering at the time I joined." The items are characterized by expressions of pride and loyalty in being part of the Navy, and the scale correlates positively so with career intent. Bureaucratic (general admin-

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TABLE 1. Means, Standard Deviations, and F-Tests for the Organizational Commitment and Role Orientation Measures by Occupational Group

Measures	HCA (n = 657) M	SD	HS&T (n = 305) M	SD	CCS (n = 422) M	SD	F (df*)
A. Organizational Commitment	25.12	4.63	24.02	4.86	23.07	5.14	23.49†
B. Bureaucratic Role Orientation	12.54	2.18	10.07	2.92	9.60	3.15	184.05†
C. Professional Role Orientation	9.36	2.10	10.57	2.22	10.62	2.35	54.52†

*degrees of frequency = 2, 1381; two records were dropped in this analysis for missing occupational group information (NOBC)
†$p < .01$

TABLE 2. Means, Standard Deviations, and F-Tests for the Organizational Commitment and Role Orientation Measures by Career Stage for Each Occupational Group

Measures	Junior Officer M	SD	Middle Officer M	SD	Senior Officer M	SD	F (df*)
I. Health Care Administration officers (n = 657)							
	(n = 360)		(n = 167)		(n = 130)		
A. Organizational Commitment	24.61	4.81	24.61	4.36	27.22	3.85	17.37††
B. Bureaucratic Role Orientation	12.59	2.22	12.28	2.19	12.72	2.04	1.73
C. Professional Role Orientation	9.78	2.08	8.83	2.13	8.88	1.90	16.56††
II. Health Sciences and Technology officers (n = 305)							
	(n = 178)		(n = 70)		(n = 57)		
A. Organizational Commitment	24.03	4.58	23.34	5.33	24.83	5.07	1.48
B. Bureaucratic Role Orientation	9.91	2.79	9.66	3.05	11.09	2.97	4.54†
C. Professional Role Orientation	10.83	2.10	10.16	2.28	10.28	2.42	2.94
III. Clinical Care Specialist officers (n = 422)							
	(n = 274)		(n = 95)		(n = 53)		
A. Organization Commitment	22.43	5.34	23.83	4.46	25.06	4.53	7.36††
B. Bureaucratic Role Orientation	9.16	3.10	10.35	3.01	10.51	3.27	7.82††
C. Professional Role Orientation	10.81	2.30	10.35	2.40	10.15	2.46	2.60

*degrees of frequency = (HCA: 2,654); (HS&T: 2,302); (CCS: 2,419)
†$p < .05$
††$p < .01$

TABLE 3. Correlations Among Commitment, Orientation, and Job Attitude Measures for the Total MSC Survey Sample (n = 1,386)

Measures	A	B	C	D	E	M	SD
A. Organizational Commitment	1.00					24.24	4.94
B. Bureaucratic Role Orientation	.36**	1.00				11.10	3.01
C. Professional Role Orientation	−.27**	−.09**	1.00			10.02	2.29
D. Overall Job Satisfaction	.35**	.08*	−.02	1.00		15.83	4.31
E. Intent to Remain in Navy	.47**	.12**	−.14**	.45**	1.00	4.00	1.28

*p < .05
**p < .01

istrative) role orientation is defined here in terms of a three-item scale which taps the individual's interest in assuming general administrative and managerial positions of responsibility, an interest which should not necessarily be compared to the stereotypical concept of "bureaucrat." The professional (occupational specialty) role orientation is defined in the present context also by a three-item scale which assesses the officer's interest in being recognized by specialists of his or her occupational field, as well as in advancing and contributing to the profession, even if not related to one's status in the Navy. Consistent with previous articles of this survey series, the analyses of this study are reported in reference to three major occupational clusters of MSC officers: Health Care Administration (HCA), Health Science and Technology (HS&T), and Clinical Care Specialties (CCS). In a similar manner, as defined in earlier reports, data comparisons are also made by career stage (junior officers with 0 to 96 months of MSC experience; middle officers with 97 to 156 months of MSC experience; senior officers with more than 156 months of MSC experience). These variables, in turn, are examined in relation to measures of overall job satisfaction and intent to remain in the Navy, again as officers reported in the survey.

TABLE 4. Correlations Between Organizational Commitment, Role Orientation, and Job Attitude Measures for Each Occupational Group

Measures	HCA (n = 657)	HS&T (n = 305)	CCS (n = 422)
I. Overall Job Satisfaction			
A. Organizational Commitment	.28**	.21**	.13**
B. Bureaucratic Role Orientation	.05	.03	−.01
C. Professional Role Orientation	−.05	.17**	.12**
II. Intent to Remain on Active Duty			
A. Organizational Commitment	.42**	.45**	.56**
B. Bureaucratic Role Orientation	.02	.17**	.26**
C. Professional Role Orientation	−.12**	−.10*	−.22**

*p < .05
**p < .01

Occupational and Career Stage Differences

Comparisons by MSC occupational cluster groups are shown in Table 1. In all the tables, higher mean scores represent higher or more favorable interest or attitude on that scale. It is evident, therefore, that Health Care Administration officers as a group report the highest level of organizational commitment, not altogether surprising since so many of that profession have extensive naval service prior to receipt of commission as MSC officers. They have in a sense grown up with the Navy. Those offi-

cers also express the highest level of bureaucratic role orientation, which makes sense in terms of their professional orientation to administration and management, not to mention the many general administrative staff billets those officers typically fill throughout their careers. That which is referred to in this study as "bureaucratic" role orientation, or general administration and managerial interest, is the Health Care Administration officers' "bread and butter." On the other hand, officers in Health Science and Technology and Clinical Care Specialties, while lower in bureaucratic role orientation, are higher in professional role orientation, consistent with their more extensive academic and graduate educational background.

When one further partitions those same groups into career stages, as in Table 2, interesting variations are observed. The difference between Health Care Administration officers and others, previously cited organizational commitment, appears to be primarily a reflection of the senior officers of that professional community. Also within that same occupational group, junior officers are significantly higher on professional role orientation than their seniors. Consistent with the substantive nature of their profession, however, the Health Care Administration officers do not differ by career stage on bureaucratic orientation. Among Health Science and Technology officers, there are no significant differences across career stages in either organizational commitment or professional role orientation. The senior officers of that group, however, report much greater interest in general administration and management than do their junior officer colleagues. Similar results are observed from the Clinical Care Specialties officers who report greater interest in bureaucratic roles and significantly greater organizational commitment as senior officers than as junior officers in general. As with the Health Science and Technology officers, and in contrast to Health Care Administration officers, professional role orientation differences do not exist among Clinical Care Specialties officers as a function of career stage.

To What are Commitment and Role Orientation Related?

The intercorrelations between attitudes and orientations of interest in this study are shown in Table 3 for all MSC officers combined. As expected from previous studies cited in the literature, overall job satisfaction and intent to remain on active duty are both significantly, and positively, related to organizational commitment. Role orientations, while also significantly correlated with organizational commitment, in different ways, are not as highly related to either job satisfaction or intent to remain in the Navy. Among MSC officers as a total group, those expressing greatest organizational identity or commitment have higher levels of general administrative role orientation and lower levels of occupational specialty role orientation.

When correlations between organizational commitment, role orientation, and job attitudes are examined separately for MSC occupational cluster and career stage groups, further differences are noted (though not tabled in this article). The highest correlations for all occupation and career-stage groups remain those between organizational commitment, job satisfaction, and intent to remain in the Navy. Most of the variance in correlation patterns, when compared across occupational and career-stage groups, is observed with the two role orientation variables. For example, the correlation between bureaucratic and professional role orientations is typically negative, though usually of zero-order magnitude and therefore virtually independent, among Health Science and Technology and Clinical Care Specialties officers. In contrast, the two role orientations are positively related among Health Care Administration officers. If one combines occupational groups and compares officers only by career stage, the results indicate that the junior officers's attitude of organizational commitment is most strongly related to role orientations, being significantly positive with the bureaucratic role orientation and significantly negative with the professional role orientation. For the middle and senior officers, by contrast, the relationships of role orientation to the other variables under study are neither consistent by occupational cluster nor by career stage. The junior officer, therefore, who regardless of professional specialty has the greatest sense of commitment to the Navy, is more likely to be interested in duties of a general administrative nature and less interested in things of a more academic peer group nature outside the Navy.

Finally, Table 4 shows how the organizational commitment and role orientation variables differ in correlational pattern with job satisfaction and intent to remain in the Navy, the data being presented by occupational cluster groups, again. For all groups the sense of organizational commitment is positively related to job satisfaction and intent to remain in the Navy occupational groups. The role orientations, however, vary differentially by occupational group in their relationship with job satisfaction and intent to remain in the Navy. More specifically, Health Care Administration officers differ in pattern from those of the clinical and science officer groups. In a future article, some of these data will be further explored relative to one's job and the extent to which one's assignment is perceived as affording challenge and opportunity congruent with role orientations and professional expectations.

Conclusion

This report has shown that role orientations and organizational commitment vary in level and in pattern among MSC officers both as a function of occupational cluster and

career stage. Although the study is not longitudinal in design, it suggests the possibility of changes in role orientation over time, and the implications such changes might have for organizational and individual effectiveness. Regardless of specific role orientations, as individuals approach occupational or career decision points, it becomes important to recognize that in most instances the worker is confronted with ambiguous, stressful, and sometimes boring situations. Two outcomes are likely when this occurs. First, feelings of conflict and curiosity will be aroused within the individual which can be channeled productively into exploring new areas of personal involvement. Second, if poorly managed, the negative aspects of the stresses which accompany career decisions can become so acute and overwhelming so as to cause withdrawal on the part of the person. This latter circumstance obviously serves no useful purpose at either the individual or organizational level. In future reports, therefore, we will attempt as well to examine the critical junctures at which transitions in role orientations are made and to identify variables which facilitate effective career planning.

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CHAMPUS Revises Guidelines on Conjoint Therapy and Collateral Visits

CHAMPUS has revised its definitions of conjoint therapy and collateral visits and removed the limit of four sessions per episode-of-care. This change is retroactive to 1 Oct 1980.

Conjoint therapy is a collective term used to indicate a category of psychotherapies where individuals, other than the therapist and the patient, are in the treatment session at the same time—i.e., one or more family members. Conjoint therapy is a form of group therapy and includes marital therapy and family therapy.

Dr. John H. Moxley III, Assistant Secretary of Defense (Health Affairs) emphasized that marital therapy should not be confused with marital counseling. He explained, "Marital counseling is not psychotherapy and does not qualify for benefits."

For the purposes of conjoint therapy the "family" is the husband, wife, or those children eligible for CHAMPUS benefits. Unmarried children who are no longer eligible for CHAMPUS benefits but who are living in the same household as the identified-patient may also participate in conjoint therapy.

A collateral visit is defined as a session between the therapist and a significant person in the identified-patient's life. It is not a therapy session. It is conducted for the purpose of information gathering and/or implementing treatment goals.

Again, for the purpose of extending CHAMPUS benefits for collateral visits, a "significant" person is generally the husband, wife, or those children eligible for CHAMPUS benefits. Others may qualify provided they can demonstrate to the satisfaction of the Program that the individual is, in fact, a "significant" person in the life of the identified-patient. An example might be a grandmother who acts as the caretaker of a minor child.

Any beneficiary who had either conjoint therapy or collateral visits rendered after 1 Oct 1980 and which were denied because the number of sessions exceeded four should resubmit the claim for reconsideration.

The present study contributes not only to the research on organizational commitment but more importantly to our own better understanding of that phenomenon among MSC officers. To evaluate the sense of commitment professional employees have toward their work organization, differences among the professions themselves need to be recognized. By way of professional practice, values, norms, and institutional affiliations, some professions may be more amenable than others to employability, acculturation, and even managerial influence or control of resources within work organizations. Interactions between type of organization and type of profession may also be important to recognize in understanding different patterns of commitment among professional employees.

The Navy differs from most organizations, however, and commissioned staff corps officers differ from most professionals employed by other organizations. And we differ most significantly on the very matters of interest in this article, organizational commitment and role orientation. We are committed by oath as well as personal honor. We serve as public officials with a special sense of pride. That is not a common sense of organizational commitment. It is special. By the same token, we are at one time professionals as naval officers just as we are health care administrators, clinicians, scientists, or whatever. Our professional roles must of necessity be many and not always easy to integrate, one with another. We are called upon to maintain both our technical or professional specialty capability and at the same time prepare ourselves for the leadership and administrative duties of an officer, responsibilities that ultimately are of a more corporate nature. I see both going on among our officers, confirming through action what the data of this study suggest in another way. I see junior officers fired up with enthusiasm and beset by frustration, seeking the opportunity to grow personally and professionally as naval officers and in their occupational specialty. I see the middle grade and senior officers in positions of considerable challenge and corporate influence, who are also being recognized through personal achievement as diplomates, fellows, officers, or by other such honors of their profession in the civilian sector of our society. It is possible, in the text of this article, for the bureaucratic (general administrative) and professional (occupational specialty) role orientations to be integrated in career naval officers. It is being done.

In addition to the research cited by the authors of the present study, the essays of Professor Charles Moskos, a noted military sociologist, are also worthy of our attention. He writes, as do others in reply to his thesis, of our changing society as reflected in the military and its tendency in recent years to change from what Moskos refers to as institutional model of organization to an occupational model (see *J Armed Forces Soc* 4(1):41-50, Fall 1977 and 6(2):257-269, Winter 1980). That is to ask, are we looking more and more to the military as simply another organization in which a person, professional or otherwise, can find a job? I would hope not, for such is contrary not only to the tradition of

service, but to our readiness for all contingencies and the real sense of commitment through pride and professionalism. These are the intangible qualities of spirit not readily measured by psychologists but understood by those who know from experience.

Again, as I have said before, I hope this series of articles on our MSC survey will serve to incite further discussion and contemplation at the local command level about careers in the Medical Service Corps, and that it be done in the context of the many complex issues affecting our professional lives including the very times in which we serve.

P.D. Nelson
CAPT MSC USN

A Navy Nurse Remembers

LTJG Bernatitus receives the Legion of Merit.

The place is Corregidor Island, the Philippines. The time is 4 May 1942, two days before the Island's surrender. "There was myself, a Navy wife, 11 Army nurses, six to eight Army and Navy officers, and two stowaways. It was an errie, moonless night and sounds of shelling from the attacking Japanese were closing in. Silently we crept into small boats and after maneuvering them beyond the touchy mine fields, we saw it. The USS *Spearfish,* our means to freedom, cast a low, dark, yet inviting shadow upon the water. As we glided closer to the submarine, our excitement mounted. And just as we pulled alongside, Japanese spot lights played on the water around us. There was no time to waste; somebody snatched my hand and pushed me down the hatch. But once inside the luminous control room, the shadowed figures of men transformed into friendly faces."

A 17-day submarine voyage to Australia through enemy infested waters might have horrified most people but not ENS Ann A. Bernatitus, NC, USN. Instead, the excursion relieved her from the horror and death she had seen on Bataan and Corregidor.

On 24 Dec 1941, Manila City, where she was stationed as a key member of the military surgical team, was evacuated. ENS Bernatitus was the only Navy nurse to go to Bataan. The remaining Navy nurses had been ordered to remain at Santa Scholastica College until further orders. Those orders never came and all 11 were taken as prisoners of war.

ENS Bernatitus and the surgical teams were spared the misfortune of becoming prisoners of war, but something perhaps as trying and uncertain awaited them. When they arrived at Bataan, they were surprised to find a warehouse filled with unmarked boxes, some containing hospital gowns wrapped in newspaper dating back to 1917. Bernatitus worked with a physician in an operating room set up with seven or eight operating tables, one next to the other in a row.

Conditions were abominable. They sterilized instruments in pressure cookers operated by kerosene. Others were placed in foot tubs filled with Lysol and then later rinsed with alcohol. "It's funny what you can do when you have to," the retired nurse said during a recent interview. "How quickly you needed the instrument determined how purely things were sterilized. She worked many exhausting hours caring for the sick and wounded, treating battle casualties in the operating room.

Ann Bernatitus may have been the first member of the Navy Nurse Corps to see front-line duty with the troops. Her Bataan hospital was in the second line of defense, and occasionally, the main defense battle line was less than 10 miles away. On 30 March 1942, U.S. Army General Hospital No. 1 became the battle zone when Japanese bombs killed approximately 60 patients and wounded about 150. During this attack, ENS Bernatitus, without regard for her own personal safety, remained in the operating room at her station working amidst the wreckage and pitiful cries of the wounded.

All together, she spent three months at Bataan moving from one improvised hospital to another. In one eight-hour shift she saw 285 patients brought into the operating room, about one new patient every two minutes! She continued to treat her own countrymen and Japanese prisoners from dawn to midnight.

Once, she remembers, the bombing became so unbearable, that it destroyed the facilities and forced the patients to evacuate. This meant quickly releasing those patients in traction. Some fell from their beds in agony. The bombing virtually destroyed the entire hospital. "It was a real mess to say the least," she added. As the Japanese invaders drew closer, the nurses were informed as to where they were being evacuated. They crept onto a bus and traveled at night down a long, windy road known as the "Zig Zag Trail." They came upon soldiers and tanks heading for the front line. When they reached the docks, they learned that the escape boat had not yet arrived. After what seemed an eternity, it appeared and carried them to Corregidor with the all too familiar sounds of gunfire echoing in the distance.

Their new refuge was a rocky island in Manila Bay, honeycombed with tunnels and divided into three

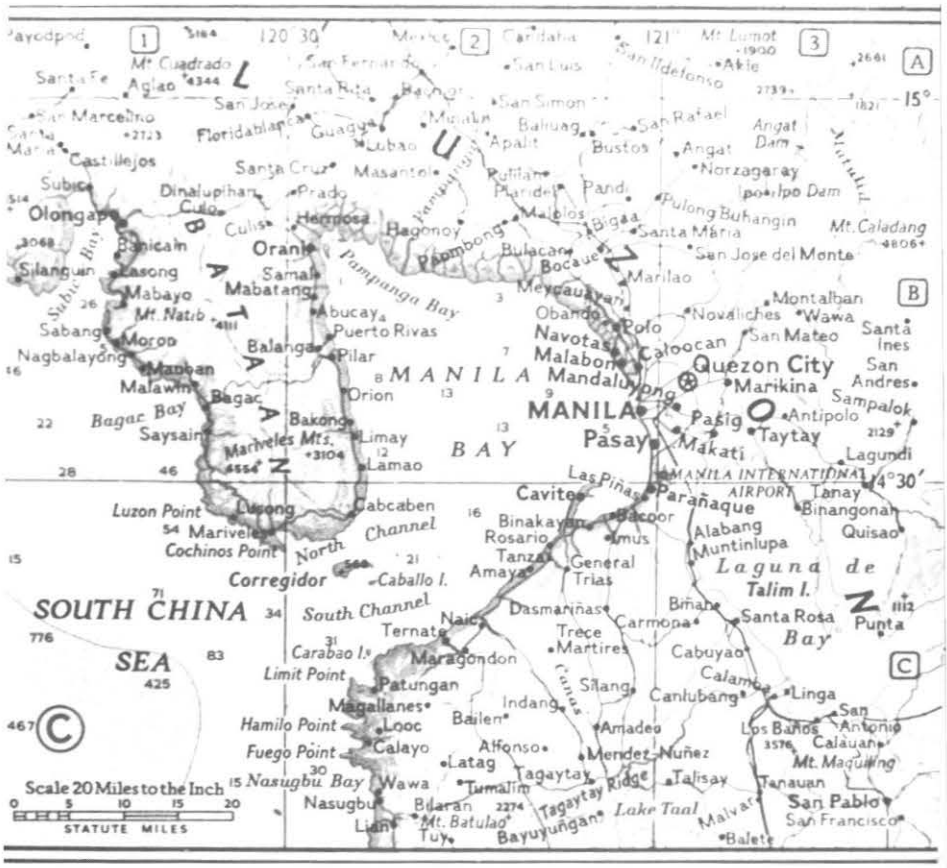
ENS Bernatitus as she appeared in a 1942 painting by LCDR Art Murry. Photo by HM2 J. Parmenter.

parts: bottom side, with its docks, middle side, with its underground tunnels, and topside, where the hospital had stood before the war. The key to survival was the tunnels. Nurses, operating teams, and the general staff lived underground like stone age cavemen in extensions off the main tunnel. Other tunnels branched off Malinta, as this main thoroughfare was called. Some of the caves served as hospital wards. Compared to what had passed for surgery at Bataan, operations performed here were considered a great improvement.

After one month on Corregidor and only two days before the island surrendered, Nurse Bernatitus ran the Japanese blockade aboard *Spearfish*. Once aboard, the nurses were treated like gold. They ate food that brought tears to their eyes. Many hadn't seen cakes, cookies, or tea in months.

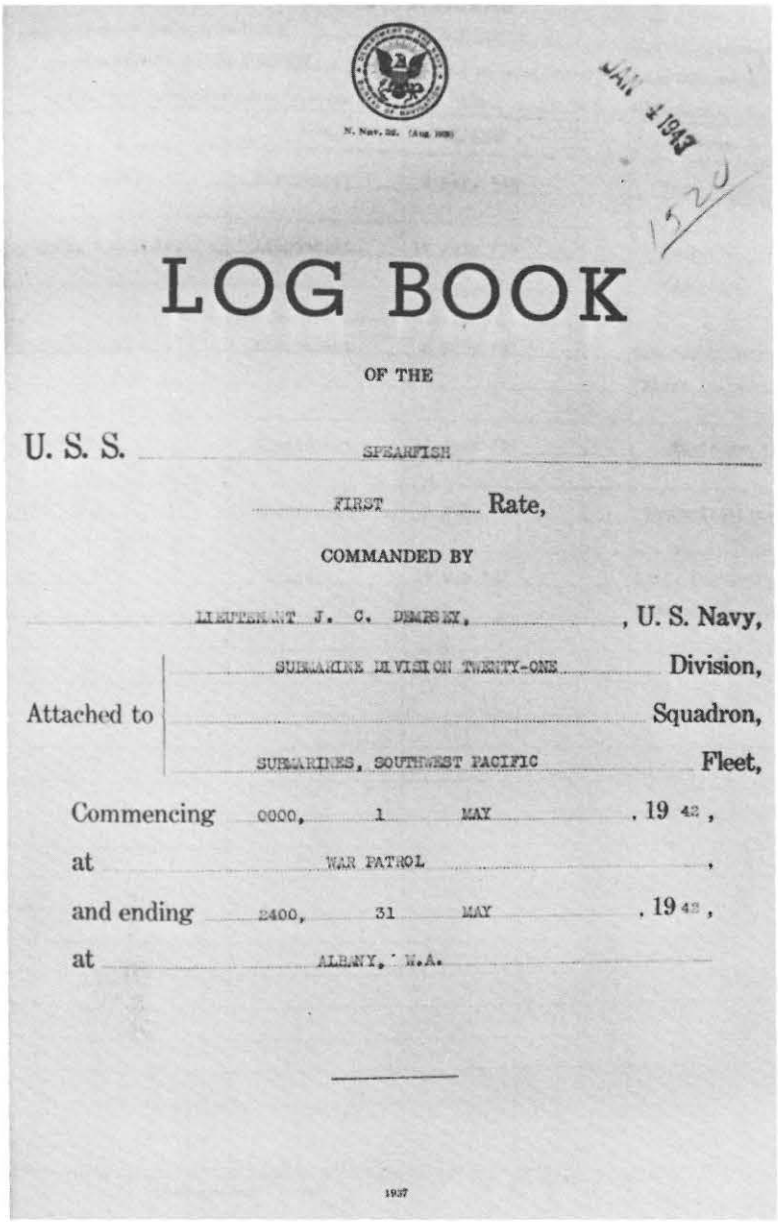
Miss Bernatitus returned to the United States during depressing times; we were losing the war in the Pacific. The morale of the American people needed a boost and it was truly a time for patriotism. Picking up almost where she left off on Corregidor, she spread her inexhaustible enthusiasm. In speeches, Bernatitus exhorted her listeners not to surrender and to support their nation in its time of greatest need. In one speech delivered at the Women at War Rally in November 1943, she brought many to tears.

> "I am particularly proud of this uniform of mine. We nurses were in uniform before the war started and we will be in uniform after the war is over . . . . No women in the world are doing a finer job than my friends in the Nurse Corps.
>
> Down in the Philippines I saw many men die—fine men. Many died with their boots on—on the field of battle—and that is the way a soldier wants to die—in action. But many died of sickness—and *that* is inexcusable because they might have been saved if we had enough supplies and medicine . . .
>
> We had too little of everything. That was the way things stood when the Japanese paid us a visit. We thought we had nothing to fear. We put huge red crosses 50 feet in size, around that field.
>
> The Japs could not have missed the crosses—and they didn't miss the beds. They used red crosses, symbols of mercy, as targets, and our boys lay there in the sun and waited for death from the sky. They were short of guns and ammunition. But they were never short of courage and their unselfishness was truly heroic.
>
> Here's a single example. One soldier knew he was a goner. He asked, 'Doctor, is there any hope at all?' The doctor reassured him and answered, 'We'll do everything we can.' The soldier said, 'Doc, get me off



Bataan and Corregidor

LTJG Bernatitus aboard USS Relief *on its way to Okinawa. The coveralls were made for the nurses at Hospital No. 1 in Little Bagio, Bataan.*



LOG BOOK

OF THE

U. S. S. SPEARFISH

FIRST Rate,

COMMANDED BY

LIEUTENANT J. C. DEMPSEY, , U. S. Navy,

Attached to SUBMARINE DIVISION TWENTY-ONE Division,

SUBMARINES, SOUTHWEST PACIFIC Squadron, Fleet,

Commencing 0000, 1 MAY , 19 42 ,

at WAR PATROL ,

and ending 2400, 31 MAY , 19 42 ,

at ALBANY, W.A.

1937

A page from the logbook of USS Spearfish.

this table and save one of those fellows that has a fighting chance.'

This was the kind of men we had at Bataan! It is too late for flowers and too soon for monuments. Remember them *now—everyday*—by turning out more and more needed equipment and supplies. Keep buying those bonds. But today—tomorrow—regularly. Don't forget Bataan!''

After the speaking circuit, ENS Bernatitus served on active duty in the United States until February 1945, when she received orders to go aboard USS *Relief* as Chief of Nursing Service for the Okinawa invasion.

When VJ Day arrived, ''I remember standing on the deck of the ship and seeing the sky filled with bright, luminous fireworks. It felt like . . . Well you just can't imagine what it felt like,'' she recalls. A few days after, the vessel went to Manchuria to pick up liberated POWs. Three and a half years after leaving Bataan, she met two physicians she had left behind. The memory of that moving reunion has not diminished.

Her valor at Bataan did not go unrewarded. In fact, she became the first person ever to receive the Legion of Merit. This award was created by an act of Congress in 1942 as successor to the Badge of Military Merit established by General George Washington in 1782. Shortly after its creation, President Franklin Roosevelt approved the presentation to then LTJG Ann A. Bernatitus.

The citation from Frank Knox, Secretary of the Navy, acting for the President, said:

> ''For exceptionally meritorious conduct in the performance of outstanding services to the government of the United States as a member of Surgical Unit No. 5 during the bombing of the Philippine Islands by enemy Japanese forces for the period December 1941 through April 1942. Constantly in the front-lines of defense in the Manila-Bataan area, and on two separate occasions forced to evacuate to new positions, Nurse Bernatitus courageously withstood the dangers and rigors of tropical combat, rendering efficient and devoted service during the tense days of the prolonged siege and evacuation.''

How does she feel 39 years later? ''My feelings are that I have never been anybody special or that I did anything special. You were in the Navy and you had a job to do and you did it, that is all.''

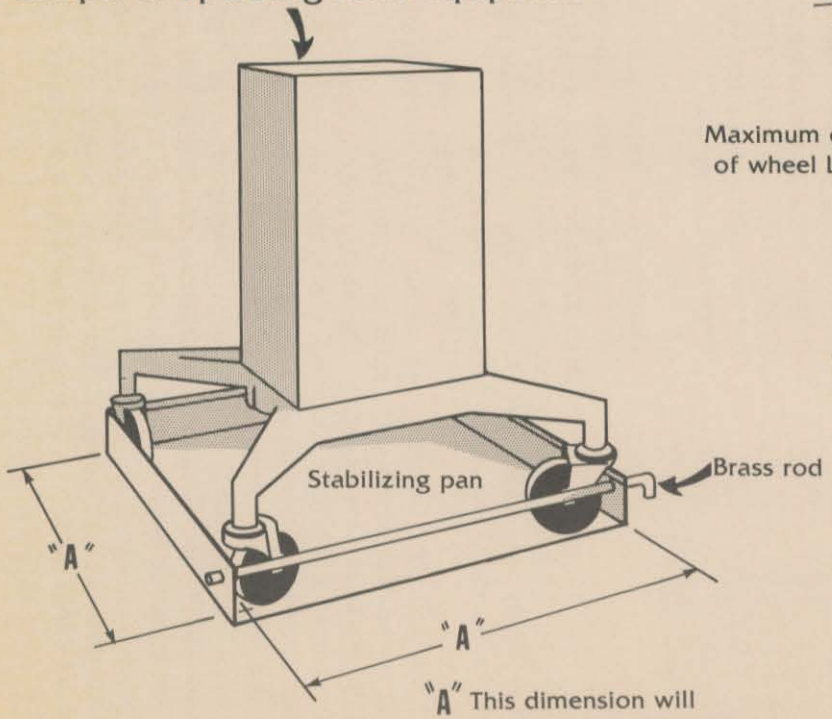
CAPT Bernatitus retired from active duty in 1959 and currently resides in Exeter, PA.

The American Defenders of Bataan and Corregidor, an organization of Army and Navy nurses, is one group that keeps her in touch with her former colleagues. In April 1980, she returned to the Philippines to help dedicate a plaque honoring those Army and Navy nurses who served their nation so valiantly.

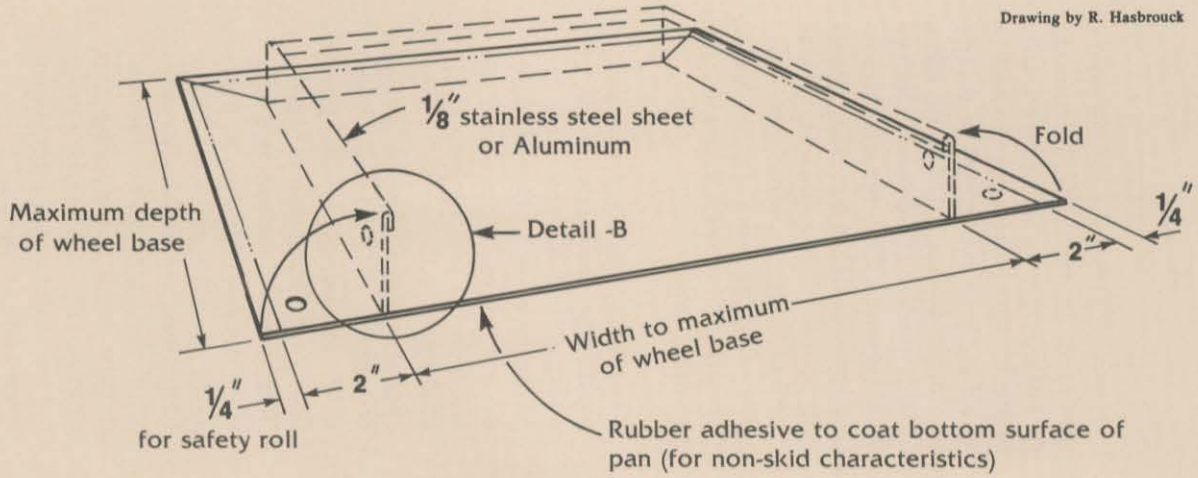
—Story by Melissa B. Rosenbaum □

Drawing by R. Hasbrouck

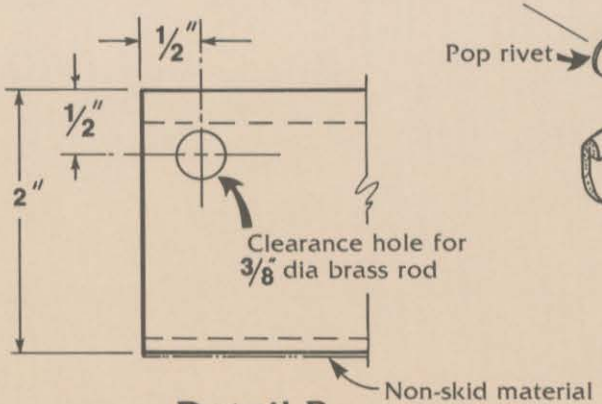
Sample of operating room equipment



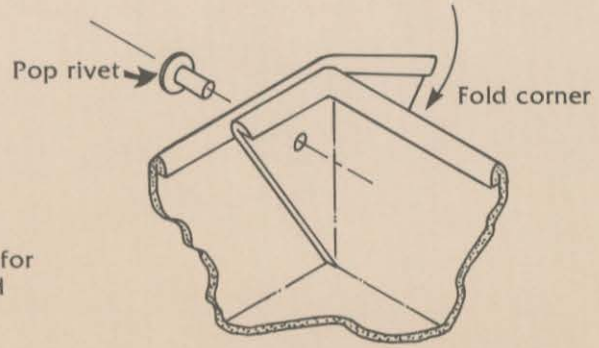
"A" This dimension will verity depending on the equipment used.



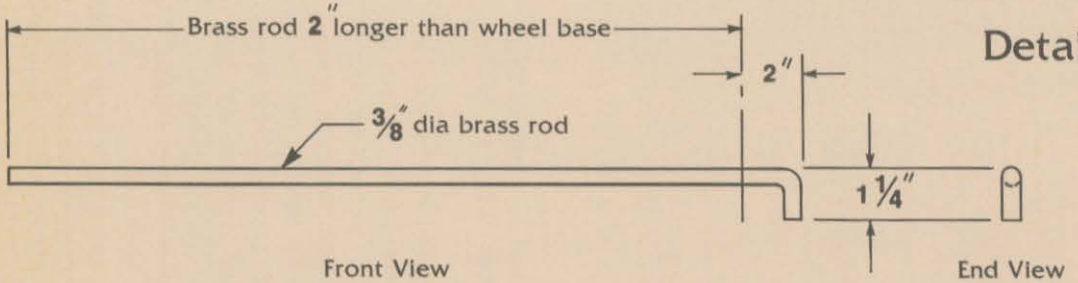
Layout of stabilizing pan



Detail-B



Corner Detail



Detail of brass rod

Department of the Navy
Bureau of Medicine and Surgery

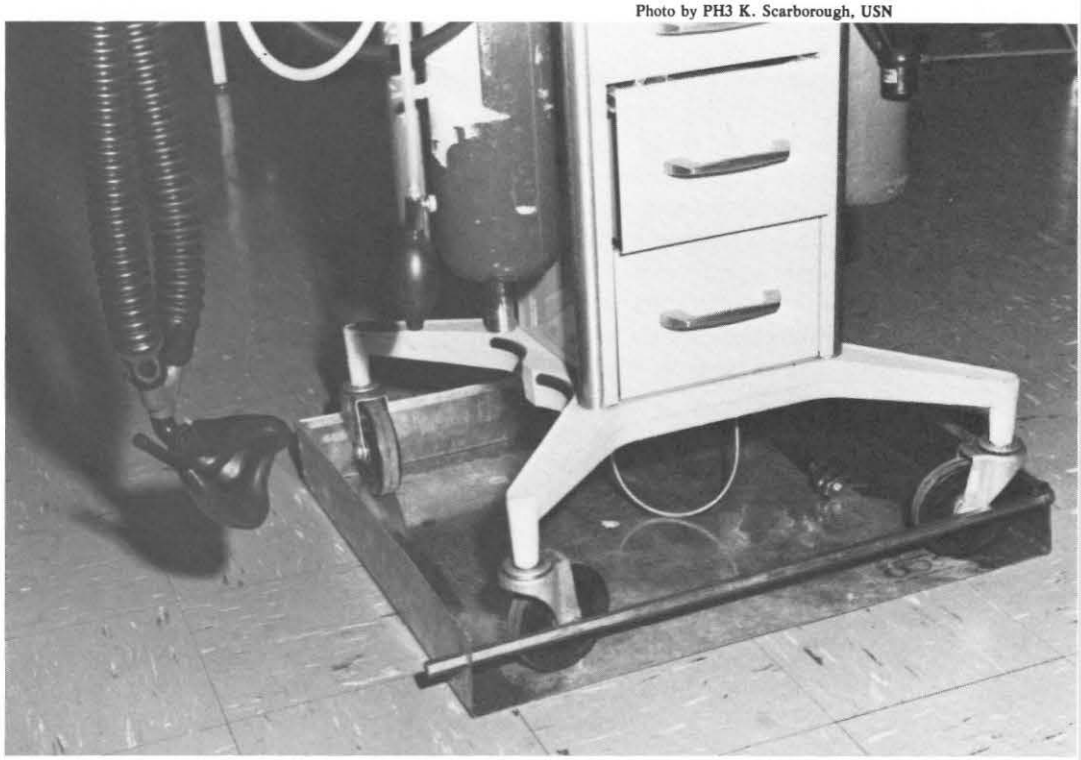
Stabilizing Device for Mobile Operating Room Equipment

Captain W. H. Petri III, DC, USN

Stabilizing Devices for Mobile Operating Room Equipment

CAPT W.H. Petri III, DC, USN

Photo by PH3 K. Scarborough, USN



Anesthesia machine in place

On ships at sea, there is the ever-present contingency that emergency surgery will have to be performed. Unfortunately, calm seas cannot always be scheduled to coincide with medical emergencies. Mobile operating room equipment (cautery, anesthesia machine, suction apparatus, etc.) is difficult to stabilize in rough seas regardless of ship size and type. Unstable equipment in the operating room constitutes a hazard to the patient, operating room personnel, and to the equipment itself. Moreover, operating room equipment manufacturers have never considered sea conditions in their designs. When not in use, wheeled equipment can be secured to stanchions, bulkheads, etc., but in-use stability is often compromised and not always successful.

Upon reporting to USS *Nimitz* (CVN-68) as Dental Officer and Ship's Anesthetist, I heard many sea stories about rolling equipment in heavy seas that made operating room personnel feel as if they were cue balls in a game of bumper pool. When I asked about previous methods of securing the anesthesia machine, the replies ranged from, "lots of strong line" to "you can't."

Since none of the previous methods of securing the anesthesia machine appeared satisfactory, I decided to try and improve the existing techniques. My basic approach was a device that would be simple to operate, easy to procure, stable, easy to store, and durable.

The mount I subsequently decided on was successfully used in 30 plus anesthetics. These devices were fabricated in the metal shop aboard *Nimitz* in about one hour's time each, and they could similarly be constructed on board most ships with metal-working capability, or aboard tenders.

The device is a square pan constructed of 1/8-inch thick stainless steel or aluminum formed to the measurement of the "wheel base" of the apparatus to be secured. One side is left open to roll the apparatus onto the pan. The apparatus is then secured by the proper length of 3/8-inch brass rod. The edges are safety rolled.

When not in use, the stabilizing pan can be secured to the bulkhead with sections of stretcher restraints.

In-use experience has demonstrated ease of manufacture, durability, security, uncomplicated use, simple storage, and safety.

Materials

- 1/8-inch thick stainless sheet steel or aluminum sufficient in size to accommodate the maximum wheel base of the equipment to be secured with 2-inch high borders on three sides which are safety rolled
- 3/8-inch brass rod of sufficient length to allow 2-inch "L" on one end
- Rubber adhesive to coat bottom surface of pan to add to nonskid characteristics □

Dr. Petri is a member of the oral and maxillofacial surgery teaching staff at NRMC Portsmouth, VA 23708.

Contact Point Management: Responsiveness is Critical!

LCDR W.F. Leadbeater, MSC, USN
LCDR H.C. Coffey, MSC, USN

Health care workers spend much of their time each day interacting with patients. During these interactions, there are two communication factors that sometimes go unnoticed.

First is a tendency to forget that each patient is different. Health care workers are frequently unaware of these differences, often judging and responding to patients with the basic assumption that all patients are the same, having similar value systems, morals, outlooks on life, etc. This viewpoint is likely to lead to ineffective responses to patients entering the health care system.

Second, during encounters there are hidden factors that have a potential influence on the outcome of even a brief meeting. Both the physical and psychological environment set the stage for each meeting. Although they are often quite subtle, these factors of influence can create a powerful atmosphere that can either hinder or enhance communication.

Developing the ability to accurately perceive and assess these influences can greatly enhance the quality of service at naval medical and dental facilities. This awareness can improve our ability to understand and respond effectively to patients' needs.

Factors of Influence

There are numerous factors and events that affect interactions with patients. For the purpose of this article, we will call these "factors of influcence." Three factors of influence woven into most encounters with patients are the environment, preconceived notions, and attitudes. These factors are not totally exhaustive nor are they mutually exclusive, but they provide a framework in which to discuss responsiveness to patients. By understanding the content and process of these factors, the skillful health care worker can enhance patient care responsiveness. Difficulties usually occur when a person is affected by one or more of these factors while the other person is not sensitive to their presence or impact.

Figure 1 illustrates the point. Both the health care worker and the patients enter into encounters carrying these influences in varying degrees. Although the diagram is simple in design, a discussion of the factors of influence will demonstrate the complexity of the meeting.

The Environment

All too often, the health care worker is quick to forget the strange environment of the hospital or clinic. People in white uniforms scurry from place to place; stainless steel carts move quickly along the corridors; a physician is paged to report to the emergency room stat; a siren can be heard in the distance; strange, medical words are thrown about by the staff. What is routine for the health care worker is frequently foreign and sometimes threatening to the patient. This is particularly true when the patient reluctantly enters the world of health care. The patient may be frightened, confused, or preoccupied with a real or perceived medical problem.

Try a simple test that may enlighten your view of the environment. If you are like most health care workers, you may have forgotten that the hospital environment has a distinct odor. Ask a patient coming in the hospital or clinic if they notice a peculiar odor. If they do, ask them to describe it. Most of the time they will describe it in very negative terms. What does this tell you and what effect do you think this smell has on the patient?

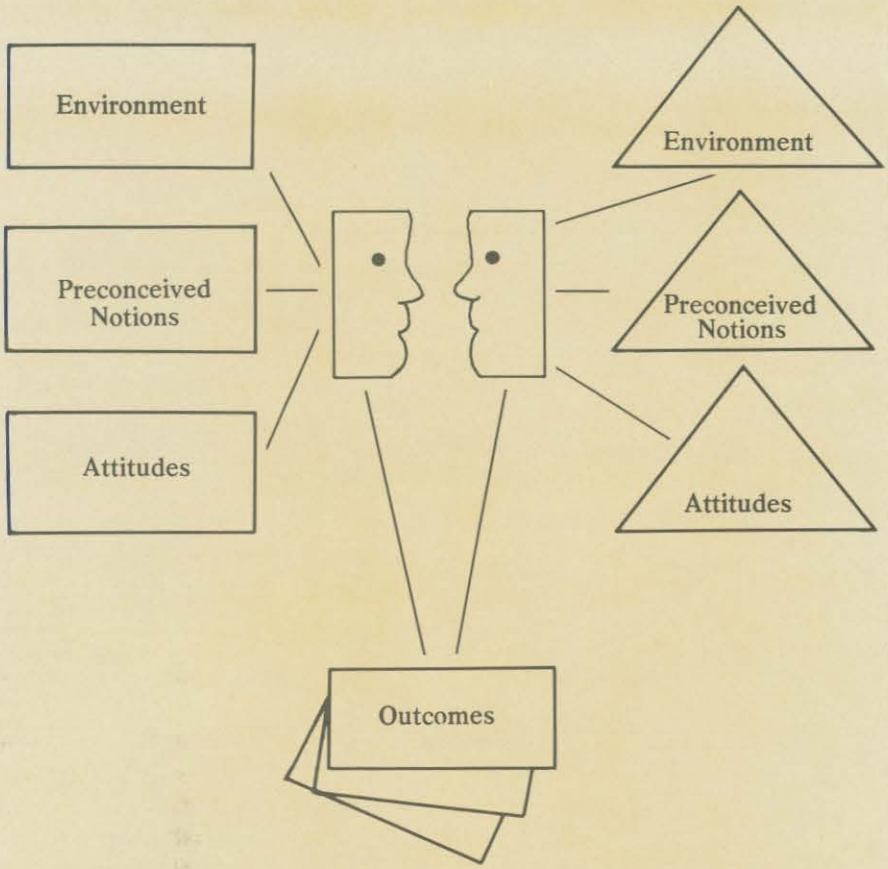
An equally important aspect of the environment is the physiological atmosphere created by the location and condition of the building. Its state of repair and the ease with which a patient can enter the health care facility are a few examples. There may be others. Try to recall the first few days at your present command. It may have taken you several days to get your bearings so that you could get from place to place without getting lost. A medical or dental facility can be a very confusing place for the new patient not familiar with the environment.

The facilities and the administrative systems are only a part of the environment. The psychological environment is at least equally important. Even the most archaic building with its intricate network of corridors and hidden clinics can be transformed by pleasant greetings, positive assistance, and a caring staff. The responsibility for creating this pleasant environment often lies with nonmedical staff members.

It is the people at reception areas and appointment phones who bear this responsibility. They are the ones who will create the psychological environment in most cases. Their responsibility is to assure that the

LCDR Leadbeater and LCDR Coffey are instructors at the Naval School of Health Sciences, Bethesda, MD 20014.

FIGURE 1. Three Factors of Influence



The factors of influence have different meanings to each person. This is due in part ot an individual's experiences, perceptions, and assumptions. If the health care worker can become aware of the presence of these influences he or she will be in a position to respond most effectively.

patient is in the best frame of mind possible when that patient enters the practitioner's office. Personnel in reception areas, by being aware of the environment that exists and the environment they create, can respond effectively to the many people they deal with every day.

Preconceived Notions

A second influencing factor that has an impact on the interaction process are preconceived notions. A preconceived notion is an idea, a judgment, or an expectation resulting from actual or imagined past experiences. These preconceived notions are projected to an upcoming event. For the most part, preconceived notions prepare people for what is to come and provide a framework for behavior. When a person's perception of reality is inaccurate, misunderstandings often occur. For example, a patient who is easily persuaded by television may have the preconceived notion that all physicians are like Dr. Welby. When preconceived notions do not match reality, there is dissatisfaction. Another example might be a patient who suffers a stroke and expects to be back playing tennis in a week. In both cases there is a good chance that the blame for the failure of these expectations will be misplaced. The health care worker should perceive this and be ready to deal with it.

Attitude

Attitude is the third factor. It is the state of mind in which one enters the encounter and has a significant influence on behavior. This state of mind can be affected by both the environment and preconceived notions.

Many people who enter a medical environment are unsure of what to expect. They may sense that they have little or no control over events that directly affect them and become very dependent or critical of every procedure. To respond effectively, the health care worker must be alert for patients at either end of the spectrum.

Responsiveness is Critical

The role of the three factors of influence play a significant part in determining the quality of our responses. Our responsiveness to patients can be enhanced by considering the following.

First, individual awareness of the factors of influence is required. Knowing and understanding patients and their individual differences can go a long way shaping our responses.

Secondly, it is imperative that health care workers approach patients with a positive attitude and an open mind. A genuine desire to serve the patients' needs is of paramount importance.

Thirdly, interest in the patient as a person is equally important. Interest can be demonstrated in many ways. Eagerness to help, courtesy and consideration, and self-imposed tolerance are but a few examples.

There are other factors that influence people in the communication process besides the three mentioned, yet the environment, preconceived notions, and attitudes provide a starting point in dealing more effectively with patients. Perhaps they are elementary in nature but they are forgotten in practice. Responsible and responsive service to patients is the hallmark of sound contact point management. □


41
RM
MARINES

An Innovation in Primary Care Afloat

LT Michael R. McKenna, MSC, USN

USS *Midway* (CV-41) initiated an outpatient appointment system for sick call on 20 Oct 1980. This system was designed to provide efficient delivery of primary care to the crew in a structured manner, and it has been a resounding success.

Prior to the establishment of the outpatient appointment system, sick call was the traditional "Everybody report to sickbay at 0800 and wait your turn." This very inefficient manner of delivering health care required some people to wait for up to three hours for evaluation or treatment by a medical officer. The ship was obviously losing many productive man-hours and supervisors were unable to determine when their people would return from the sick call line. Accordingly, alternative methods of providing health care were discussed.

The response of the medical staff was to implement an outpatient appointment system for sick call. The staff elected to schedule appointments for the general medical officer and for the two Airwing FIVE flight surgeons. The physician's assistant was assigned primary responsibility for emergency room treatment and the general surgeon was scheduled appointments on a consultation basis during regular hours. The senior medical officer assumed responsibility for scheduling his own appointments around his varied administrative duties.

The new system was set up with 15-minute appointment intervals between 0800 and 1100 for each medical officer. A walk-in sick call from 0745 to 0845 was maintained for personnel without an appointment. New appointments were not scheduled for the medical officers in the afternoon. This time instead was used to allow each individual physician to schedule his own patients for followup or for a more lengthy evaluation. The afternoon scheduling also provided flexibility, allowing the flight surgeons to work with the air wing and to schedule their required flight time.

The ship's newspaper and a printed flyer publicized the new appointment system, and the senior medical officer briefed the ship's company over closed circuit television. The appointment system was an immediate success. The acceptance rate of the crew was high and the medical personnel readily adapted to the new routine. The difficulties inherent in making the transition to the new system were few.

When the outpatient appointment system was instituted in October 1980 the average at sea sick call census was approximately 100 patients daily. The current average at sea sick call census is approximately 70 patients a day. The overall reduction in daily census was primarily the result of discouraging personnel who had previously used the sick call system for secondary gain, avoiding their workspaces for prolonged periods while standing in the long lines.

The advantages of the outpatient appointment system were numerous and became readily apparent. They included:

- greater patient satisfaction and convenience;
- more timely evaluation of patients with significant medical problems;
- more efficient use of the treatment/emergency room by reducing routine screening hours and freeing the facility for response to treat emergencies;
- more efficient manpower planning by allowing work center supervisors to send personnel to medical spaces at specified times with minimal anticipated waiting time;
- flexibility in scheduling of appointments;
- greater management of limited resources such as personnel and material; and
- improved physician satisfaction by allowing better management of available physician time and resources.

One major benefit that developed that had not been anticipated was that not all medical officer appointments available were booked, allowing time to be set aside for scheduling physical examinations which had previously been available only in the afternoons. Another major outgrowth of the system was the development of a separate clinic for patients with viral syndromes, staffed by a corpsman conducting routine screening and treatment. Some patients were referred to the medical officers for evaluation. This effectively reduced the medical officer's clinical load of routine viral complaints appropriately screened and treated at the corpsman level.

An outpatient appointment system has been functioning for almost four months aboard USS *Midway* and has been an unqualified success. The medical staff, the hospital corpsmen, and, most importantly, the crew, support the concept as an important innovation in providing total health care to the ship's company and air wing. The system is readily adaptable for use aboard all large naval vessels with only minor modifications tailored to each ship's needs. □

LT McKenna is Medical Administrative Officer aboard USS *Midway*.

The Equal Opportunity Program

LCDR Aaron McClerklin, MSC, USN LCDR Tommy L. Ruffin, MSC, USN

The most challenging problem facing the Navy, including the Navy Medical Department, today is the retention of trained, quality individuals of all ethnic backgrounds. There are a number of reasons why individuals opt to leave the Navy. Some are beyond the control of the command, the Medical Department, the Department of the Navy, and the Department of Defense. One of the biggest factors, however, in making a decision to "stay" or "go" is the person's perception of his/her value to the Navy. Usually, this is determined by how the individual is treated by the organization in terms of opportunities for professional and personal development and growth, increased responsibilities, recognition, and acceptance.

To stem the exodus and maintain a high state of readiness, the Navy has initiated many affirmative actions to insure that each individual is afforded equal opportunity and access to Navy programs and experiences necessary (or desirable) for professional development and growth. The first major action was the initiation of Phase I of the Equal Opportunity/Race Relations (EO/RR) program in 1971, better known as the Upward, Executive, and Flag seminars. The purposes of the EO/RR (Phase I) program were: (1) to expose practices that denied individuals equal opportunity and equal access to Navy opportunities primarily because of race, creed, color, religion, or national origin and (2) to demonstrate conclusively how such practices also negatively affect the command and the Navy. The EO/RR (Phase I) program was a growth experience. It heightened the concern for the individual and became the foundation for future "people oriented" initiatives.

In the years that followed, the Navy placed more emphasis on people. In 1972 CNO called for actions to address sexism within the Navy. Also, sensing that the EO/RR (Phase I) program had peaked, the EO/RR (Phase II) program was promulgated in the fall of 1974, known to most as the *Equal Opportunity Program.* Building upon the awareness created by the EO/RR (Phase I) program, the Equal Opportunity program focused on the identification and the elimination of discriminatory and insensitive practices through affirmative actions. The design of the EO program differs markedly from the EO/RR (Phase I) program in that it is more flexible; it can be molded to meet command specific needs; it is not time oriented; and it has as an objective the accomplishment of affirmative actions leading to the equal treatment of and equal opportunity for all personnel.

In support of the Equal Opportunity program, BUMED established two Equal Opportunity Program Specialists (EOPS) Teams. The mission of the EOPS Teams is to assist Medical/Dental activities with the implementation of their EO programs and provide followup assistance and consultatory service upon request or as required. Each team is staffed with one officer (OIC) and seven enlisted billets. Team members are volunteers and receive equal opportunity training at the Equal Opportunity Management Institute (EOMI), Patrick AFB, FL, prior to joining a team. Additional time is required to mold each person into an effective team member.

How can an EOPS team help a command? First, it should be pointed out that taking advantage of the services offered by an EOPS team is not a confession or an indication that a

RADM E.P. Rucci, MC, CO at NRMC San Diego, is briefed by HMCM Lawrence Davis (middle), senior enlisted member of the West Coast EOPS Team.

LCDR McClerklin is OIC, Equal Opportunity Program Specialists Team, NRMC Oakland, CA 94627.

LCDR Ruffin is Equal Opportunity Assistant (MED 001E), BUMED, Washington, DC 20372.

command has problems. What it does say is that the CO/OIC not only is interested in preventing problems but making improvements as well. The EOPS team will assist the command with the key elements of the EO program and provide assistance in other areas as requested by the command. The team will:

• **Assist the command in data collection and climate assessment.** Surveys, interviews, equal opportunity quality indicators, observations, etc., are data collecting methods employed to facilitate climate assessment. The EOPS Team will analyze the data and provide feedback to the CO/OIC. The CO/OIC determines the significance of the data to his/her command.

• **Conduct required equal opportunity and race relations training.** There are several workshops targeted for different groups. The workshops are not the same as, nor are they an extension of, the EO/RR (Phase I) Seminars. The team will conduct the following workshops:

(a) Counter Racism/Equal Opportunity (CR/EO) (CO/DCS/DAS/DNS/Chief of Services)

(b) Actions to Counter Racism (ACR) (E-6 and above, excluding the CR/EO group)

(c) Women in the Navy (WIN) (All Hands in peer groups)

(d) Cultural Expression in the Navy (CE) (All Hands in peer groups)

(e) Military Rights and Responsibilities (MR&R) (E-5 and below)

• **Train a command training team (CTT).** The EOPS Team will train and certify designated command personnel to conduct the Military Rights and Responsibilities and Cultural Expression in the Navy Workshops.

• **Conduct an affirmative action plan (AAP) workshop.** The workshop is designed to take the AAP development group through some fundamental steps for constructing an AAP. The actual development of the AAP is the *absolute* responsibility of the command.

LCDR R.F. Coxe, MSC, OIC of East Coast EOPS Team, fields questions from Human Resources Management survey participants.

• **Provide training for the human relations council (HRC).** This workshop addresses the duties and responsibilities of the HRC and problem identification techniques.

As previously pointed out, the teams also act as consultants. They will consult with a command, upon request, and design an "assistance package" to meet the command's needs. It is important that their role of "assisting" be kept in proper perspective.

The job of the EOPS Teams is not easy. They spend a great deal of time on the road. An assistance visit can take several weeks or four to five months depending on the size of the activity and the range of assistance required/requested. Between assistance visits, the teams hone their skills and refine their techniques. Team members say the work is demanding but rewarding. "I volunteered for this job," said BT1 Forest C. Gwynn, member of the east coast EOPS Team, "because I saw a need and felt that I could make a contribution."

Do they still encounter resistance? "Yes," say members of both teams, "but not as much as we did in the past, which is an indication of progress." Teams' members explained that they still encounter individuals who do not believe that persons of all races and both sexes can be and are indeed denied equal opportunity be it an act of commission or omission. "We must be careful not to meet this resistance with force," explains HMC Danny M. Barron, member of the west coast EOPS Team. "It is not our intent or mission to impose our views or philosophy on others. We must, however, impart to others an understanding and the skills necessary to support the intent and the spirit of the Equal Opportunity policy of the Navy and the Navy Medical Department."

The teams are located at NRMCs Portsmouth, VA, and Oakland, CA. They will provide EO program assistance to an activity upon request at no cost to the activity. To request assistance, contact the nearest Team or BUMED (MED-001E). EOPS Team, NRMC Portsmouth, commercial (804) 398-6957, EOPS Team, NRMC Oakland, (Autovon) 855-2576, and BUMED (MED 001E), (Autovon) 294-4332/Commercial (202) 254-4332. □

Home Monitoring of Blood Glucose

LCDR James W. Jung, NC, USN

Urine testing alone for the diabetic does not always give an accurate assessment of diabetes control. The Diabetes Clinic at NRMC Oakland, uses either the Ames Dextrometer or the Chemstrip bG to enable the patient to obtain a blood glucose reading at home.

The Ames Dextrometer measures the color change on the Ames Dextrostix Reagent Strip and displays the results digitally in mg/dl glucose in whole blood. A simple system of standards and controls assures test reliability. A read-out ranging from 0-399 mg/dl is obtained in two minutes.

Chemstrip bG is a test strip that contains a test area sensitive to blood glucose levels. A drop of whole blood is placed on the reactive section; a minute later the blood is dabbed off with cotton; after another minute, the test is compared with a color chart on the side of the Chemstrip container. If the reading goes above 240 mg/dl, one must wait another minute before making a final reading. The range of glucose readings is 20-800 mg/dl. The test strips may be cut in half lengthwise to double the number of tests from one container (cost is $.50 per test, or $.25 when test strip is cut in half).

Home blood glucose monitoring offers several advantages:

- true blood glucose control is shown at home or at work;
- a clear picture of renal threshold is obtained;
- appropriate diet may be determined;
- the patient may adjust his own insulin;
- the patient is aware that when blood glucose is in normal range he can run negative urines for glucose;
- effects of exercise are shown;
- hypoglycemia may easily be identified;
- the patient may see how noncompliance can effect his control;
- by making decisions that affect him, he becomes more involved with his disease;
- the pregnant diabetic may maintain herself in an outpatient setting and have a normal delivery.

Patients who are chosen by the physician or diabetes educator must be alert, motivated, and educated about their disease and its control. The educator assesses the patient's knowledge and sets up an individual program for the patient using one-to-one contact and diabetes classes held at NRMC Oakland every Thursday.

At the onset, responsibilities of the physician or educator and the patient are clarified. Physician or educator's responsibilities are:

- explain the meaning, importance and advantages of blood glucose testing at home;
- set up a testing schedule;
- teach the patient how to collect blood, perform the test, and interpret results;
- observe the patient during a return demonstration;
- provide a schedule of adjusting insulin;
- give the patient a system to record results;
- set up a schedule of followup visits;
- review the testing record and testing technique.

The patient's responsibilities are:

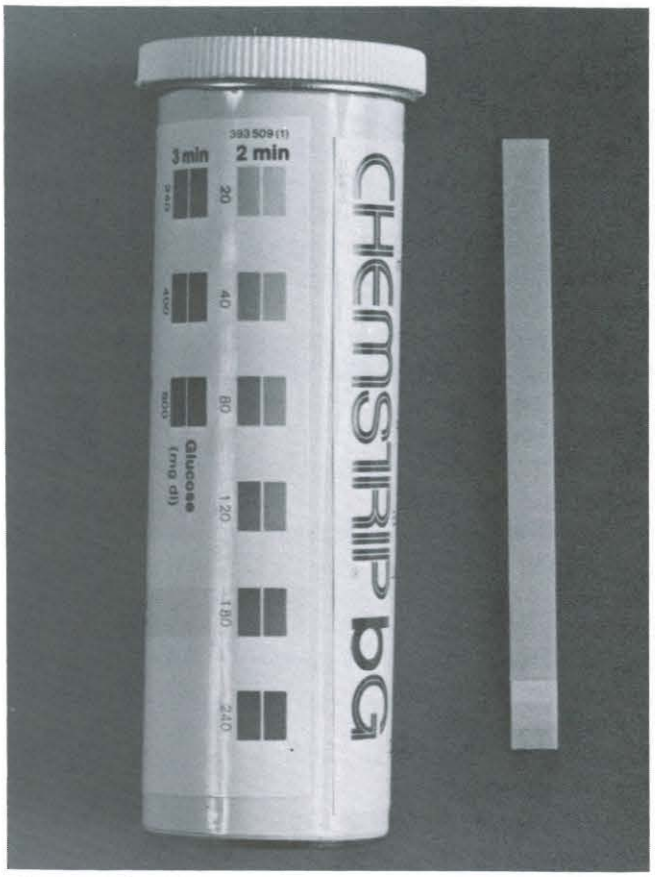
- understand the importance of blood testing;
- determine a testing schedule;
- learn the technique of testing blood glucose;
- perform the tests at the times agreed;
- adjust insulin dosage as indicated;
- record test results;
- discuss the results with the physician or educator.

The patient maintains a blood glucose diary that he brings with him to return visits (Figure 1). During a return visit the patient's blood is checked against the Yellowsprings Instrument's Glucose Analyzer and the technique of measuring their blood glucose is reviewed. Clinic patients routinely have hemoglobin A_1s drawn to follow their control. The patient is provided with the clinic phone number so he may call for assistance.

The diabetic who chooses to participate in the home monitoring program has a chance to become better educated about his disease, actively participate in its control, and reduce hospitalization due to complications or poor management of a chronic illness that affects over 10 million Americans. □

LCDR Jung is a Diabetes Educator at NRMC Oakland, CA 94627.

Ames Dextrometer glucose analyzer.



Chemstrip bG blood analysis strips.

FIGURE 1. Home Blood Glucose Diary

NAME _____

Date/Time		Date/Time		Date/Time		Date/Time	
Mounted bG Strip	Blood Test Reading	Mounted bG Strip	Blood Test Reading	Mounted bG Strip	Blood Test Reading	Mounted bG Strip	Blood Test Reading
	Urine Test Reading		Urine Test Reading		Urine Test Reading		Urine Test Reading

Navy Graduate Medical Education

The Surgeon General's Specialties Advisory Conference Committee (SAC) will meet in the Washington, DC, area from 20-25 Sept 1981. The purpose of this conference is to nominate graduate medical education (GME) trainees for 1982 and to discuss issues regarding Navy Medical Department graduate medical education programs.

Interested applicants should make application before the deadline of 15 Aug 1981. The applications may be obtained from the local command or from the Naval Health Sciences Education and Training Command (Code 31), National Naval Medical Center, Bethesda, MD 20014, Autovon 295-0648.

BUMEDINST 1520.10G and BUMED Notice 1520 contain appropriate instructions for submitting applications.

Applicants to be considered for GME training in 1982 must have a projected rotation date (PRD) from their present command which will correspond to their availa-

Programs in Graduate Medical Education Offered to Graduating Medical and Osteopathic Students in the 1982—1983 Training Year

	Fam Prac	Ob/Gyn	Path	Peds	Psych	Basic Med	Basic Surg	Total
Bremerton	4							4
Camp Pendleton	9							9
Charleston	10							10
Jacksonville	12							12
Pensacola	8							8
Bethesda		3	1	2	4	24	16	50
Oakland		3	2	2	3	20	15	45
Portsmouth		6	1	3	4	22	18	54
San Diego		6	3	3	4	35	24	75
Total	43	18	7	10	15	101	73	267

NOTES: (A) 1st year programs in Path, Fam Prac, Ob/Gyn, and Peds will be 12 months in a single discipline but shall contain rotations in related specialties.

(B) Programs in Psych will offer a broad based clinical year to include 4 months in Int Med, not more than 3 months in Psych, plus electives.

(C) The Basic Med and Basic Surg training year will contain a minimun of 4 months of Int Med, 4 months of Surg, plus electives. These programs are structed in order to provide the trainee with the background required to enter training in specific specialties at a later date. Current plans are that trainees in Basic Med will be prepared to enter residency programs in Anes, Derm, Int Med, Neurol, Ophth, and Radio. Basic Surg trainees will be prepared to enter residency programs in all surgical specialties including Oto, Ortho, Gen Surg, and Neuro Surg. With the exception of Fam Prac, ample opportunities will exist for crossovers into other specialties after completion of the first year of GME in any of the programs listed above. Those interested in being considered for a second year (GME-2) Fam Prac position must have completed 2 months of obstetrics and 2 months of pediatrics during their GME-1 year. Acceptance at the GME-2 level for any specialty must be recommended by the Surgeon General's Advisory Committee after review of the GME-1 year rotations.

(D) Electives will be offered according to the trainee's preference as approved by the program director.

Navy Residencies/Fellowships

	Years of Training Offered	# of Positions Each Year	Bethesda	Bremerton	Camp Pendleton	Charleston	Jacksonville	Oakland	Pensacola	Portsmouth, VA	San Diego	
Aerospace Medicine (1)*	3	3						3				
Anesthesiology *	2/3	20	6				4		4	6		
Dermatology *	3	6	2							4		(R
Family Practice *	2/3	41		4	9	9	10	9				(R
Hand Surgery	1	2					2					
Internal Medicine *	3	26	5				3		7	11		(R
Cardiology	2	6	2							4		
Endocrinology	2	3	2				1					
Gastroenterology	2	4	2							2		
Hematology/Oncology	3	4	2							2		
Infectious Disease	2	4	2							2		
Nephrology	2	2							1	1		
Pulmonary Disease	2	4	1						1	2		
Rheumatology	2	1								1		
Neurology	3	2	2									(R
Neurosurgery *	4	1	1									
Nuclear Medicine	2	3	2				1					
Obstetrics & Gynecology *	3	18	3				3		6	6		
Maternal Fetal (4)	2	1	1							1		
Ophthalmology *	3	9	4				2			3		
Orthopedic Surgery *	4	12	2				3		3	4		
Otolaryngology *	4	10	2				3		2	3		
Pathology *	4	8	2				2		2	2		(R
Hematopathology	1	1	1									
Pediatrics *	2/3	16	3				3		5	5		(R
Adolescent Medicine	2	1								1		
Pediatric Hematology	2	1								1		
Plastic Surgery	2½	1							1			
Psychiatry *	3	12	3				3		3	3		(R
Radiology (Diagnostic) *	3	17	5				4			8		(R
Radiology (Therapeutic) *	3	1								1		
Radiology fellowships (2)	1	2								2		
Surgery, general (3)*	4/5	14	3				3		4	4		
Peripheral Vascular	1	1								1		
Thoracic & CV Surgery	2	2	1							1		
Urology *	4	6	1				1		2	2		

*Indicates number of years training beyond GME year one.

(1) One year outservice for Masters Degree and 2 years inservice—positions shown reflect inservice positions only.

(2) Neuroradiology, angiography, pediatric radiology, ultrasound/computed tomography, and nuclear radiology—only two fellowships will be filled each year.

(3) If the first GME-1 year was not completed in an accredited surgery program consisting of 6 months of surgical rotations, the length of time required will be 5 years after GME-1.

(4) One position every other year at San Diego location.

bility for training. This date should be checked with the local command or the Naval Military Personnel Command detailer. Applicants whose PRD is not compatible with the anticipated GME start date cannot be considered for selection at this SAC conference.

Contact points for information regarding GME and detailing are as follows:

CAPT Charles Mock, MC, USN
Director, Medical Corps Programs
Naval Health Sciences Education and Training Command
(Code 31) Autovon 295-0648

CAPT James H. Black, MC, USN
Medical Corps Assignments
Naval Military Personnel Command
(NMPC 4415M) Autovon 225-7960

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(NMPC 4415N) Autovon 225-7960

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